

1 **BOARDS OF MEDICINE AND OSTEOPATHIC MEDICINE**
2 **PAIN MANAGEMENT CLINIC STANDARDS OF PRACTICE**
3 **JOINT COMMITTEE MEETING**

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6
7 **September 10, 2010**
8 **8:08 a.m. -- 1:22 p.m.**
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11 **Hyatt Regency**
12 **Orlando Airport**
13 **Orlando, Florida**

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24 **Reported By:**
25 **Heather K. Howard, Court Reporter**

PERSONS PRESENT:

FRED BEARISON, M.D., CHAIR

RONALD BURNS, D.O., VICE-CHAIR

STEVEN P. ROSENBERG, M.D.

ELISABETH D. TUCKER, M.D.

JOEL ROSE, D.O.

GARY WINCHESTER, M.D.

BRIGITTE GOERSCH, CONSUMER MEMBER

LARRY MCPHERSON, EXECUTIVE DIRECTOR

ANTHONY JUSEVITCH, EXECUTIVE DIRECTOR

ED TELLECHEA, ESQUIRE

DONNA MCNULTY, ESQUIRE

NANCY MURPHY, PARALEGAL

CRYSTAL SANFORD, PROGRAM OPERATIONS ADMINISTRATOR

CHRISTY ROBINSON, PROGRAM OPERATIONS ADMINISTRATOR

KIM BERFIELD, DOH DEPUTY SECRETARY

LUCY GEE, MQA DIVISION DIRECTOR

EULINDA SMITH, DOH COMMUNICATIONS OFFICER

HEATHER K. HOWARD, COURT REPORTER

ROBERT SANCHEZ, AUDIO SPECIALIST

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P R O C E E D I N G S

September 10, 2010

8:08 a.m.

MR. MCPHERSON: People who wish to speak this morning, if you have not filled out the yellow speaker card which is located against the wall there on the table, please fill one out and give it to Ms. Sanford.

Even if you submitted written material we are still asking that you fill out that yellow speaker card so we can determine how many people wish to speak and make sure that you have the opportunity to do so.

Thank you.

CHAIRMAN BEARISON: Good morning everybody. For the record, my name is Dr. Fred Bearison. I'm the Chairman of the Boards of Medicine and Osteopathic Medicine. I'm Chairman of the Committee though.

The Boards of Osteopathic Medicine Pain Management Clinic Standards of Practice Joint Committee. It is September 10, 2010 and we are at the Hyatt Regency Orlando International Airport.

Mr. McPherson, will you please call roll?

1 MR. MCPHERSON: Yes, sir. Dr. Bearison?

2 CHAIRMAN BEARISON: Present.

3 MR. MCPHERSON: Dr. Burns?

4 VICE-CHAIR BURNS: Present.

5 MR. MCPHERSON: Ms. Goersch?

6 MS. GOERSCH: Here.

7 MR. MCPHERSON: Dr. Steven Rosenberg?

8 DR. ROSENBERG: Present.

9 MR. MCPHERSON: Dr. Tucker?

10 DR. TUCKER: Present.

11 MR. MCPHERSON: Dr. Rose?

12 DR. ROSE: Present.

13 MR. MCPHERSON: Dr. Winchester?

14 DR. WINCHESTER: Here.

15 MR. MCPHERSON: Also present Anthony
16 Jusevitch and Larry McPherson, Executive
17 Directors.

18 Donna McNulty, Ed Tellechea, Board Counsel.

19 Nancy Murphy, Paralegal.

20 Crystal Sanford and Christy Robinson,
21 Program Operations Administrator.

22 You have a quorum, Mr. Chair.

23 CHAIRMAN BEARISON: Thank you,
24 Mr. McPherson.

25 First what I'd like to do is to go ahead

1 and ask Mr. McPherson to give us a brief
2 overview of why we're here, a little bit about
3 past events and what our plans and expectations
4 are for today's meeting.

5 Mr. McPherson.

6 MR. MCPHERSON: Thank you Mr. Chair.

7 This meeting of the Joint Committee is
8 being held today to address rule making in order
9 to implement legislative provisions on pain
10 management clinics. The purpose of today's
11 meeting is to address two specific items in
12 those pain clinic statutes.

13 Item number one which will be addressed
14 first by the Committee is accreditation. The
15 statute provides that in lieu of an annual
16 inspection by the Department of Health, that a
17 Board approved organization that has accredited
18 a pain management clinic would be acceptable
19 instead of having an annual inspection.

20 So the first item is to determine what
21 standards should the Boards have in deciding who
22 would be approved as a national -- who would be
23 approved as an accrediting organization. These
24 organizations have to be Board approved. In
25 order for the Boards to approve them, they have

1 to have standards. So step one, what standards
2 should there be for approving accrediting
3 organizations.

4 The second item is the statute requires
5 that the Boards developed a rule that places a
6 limit on the number of schedule two and three in
7 Alprazolam that can be written at a pain
8 management clinic during a 24-hour period. So
9 that would be the second item.

10 And for both of these items we have
11 received material from interested parties. The
12 Board members, the Committee members have
13 received those materials. They either have them
14 on a disk using their laptop. Some may have
15 paper copies. Paper copies of all the materials
16 they have are located on that table for your
17 review.

18 The Committee would ask that if you're
19 interested to speak, please fill out a speaker
20 card. Beginning with accreditations the
21 Committee will ask for those who wish to speak
22 to come forward. We understand that there is a
23 lot of interest and a lot of passion in some of
24 these issues. We would ask everybody to please
25 be mindful of that. We will certainly treat you

1 with respect and we would like you to treat the
2 Board members with respect in your
3 presentations.

4 The Chair has said that with regard to
5 lunch, I guess we'll need to see how we are
6 progressing, but we anticipate there'd be a, you
7 know, a break at about 10. And then whether or
8 not we take a lunch break will depend upon how,
9 you know, how we're proceeding.

10 So is there anything else, sir,
11 administratively or Mr. Tellechea, Donna
12 McNulty?

13 CHAIRMAN BEARISON: Thank you
14 Mr. McPherson.

15 Before we formally get started, I would
16 just like to take a minute to again thank very
17 much my fellow Committee members. This has been
18 a long arduous task, and I'm sure it's going to
19 continue on and it's taking an extraordinary
20 amount of time out of everybody's busy day. As
21 I'm sure most of you in the audience know that
22 the members of this Committee, the doctors, the
23 MDs, the DOs and our council members, we don't
24 get paid to do this. It's all volunteer work.
25 So, again, I want to thank very much my

1 Committee members for taking all the time that
2 they have in order to accomplish what we need
3 to.

4 And second, I would like to also thank the
5 staff because this is just extra work for them
6 in addition to doing their daily work which is
7 enormous. They've also be saddled with this
8 responsibility to get us all the information
9 ready for the meeting. So, again, I want to go
10 ahead and thank the staff for everything that
11 they've done in order to get us where we are
12 today and get us the materials in a prompt
13 manner so we had time to review them.

14 What I'd like to do first then is to go
15 ahead and discuss the first issue of the
16 accreditation agencies, and we'll go ahead and
17 hear testimony on that. And then when we decide
18 that portion is complete, then we'll go ahead
19 and shift over to discuss the second issue which
20 is the prescription issues.

21 So what I'd ask of the speakers is to stay
22 very focused. If you want to speak on both
23 issues, that's absolutely fine, but again I
24 don't want to mix the two. I want to just have
25 you first speak on the first topic, and then

1 later when we discuss the second topic, you can
2 come back and discuss that. But please limit
3 your comments specifically to that first issue.

4 I think we'll go ahead and start with the
5 speaker cards. They're in no specific order.
6 At this point in time -- how many do we have
7 Mr. McPherson? Approximately.

8 MR. MCPHERSON: 1, 2, 3, 4, 5, 6, 7.

9 CHAIRMAN BEARISON: Okay. So we have seven
10 cards. So at this point I'm not going to set
11 any specific time limit, but I would anticipate
12 that nobody is going to be speaking for more
13 than let's say 10 to 12 minutes. So we can kind
14 of keep that in the back of our minds, but we
15 have 12 so far that we can -- people stay
16 focused then 10 minutes would be a reasonable
17 amount of time for them to get their point
18 across.

19 Mr. McPherson?

20 MR. MCPHERSON: Mr. Chair, perhaps as a
21 starting point all members have been provided
22 with a copy of the current rule on accreditation
23 of organizations for office surgery. That
24 actually sets out a lot of the issues that the
25 Committee may feel would be appropriate for the

1 work today.

2 So if -- you might want to look at that.
3 Look at the accreditation standards for office
4 surgery. I think that would be a good starting
5 point as we approach the accreditation issue and
6 of course copies of that rule are on the table
7 for the public.

8 CHAIRMAN BEARISON: Mr. McPherson, that's
9 this here?

10 MR. MCPHERSON: Right.

11 CHAIRMAN BEARISON: And everybody has --

12 MR. MCPHERSON: Does everybody have that?

13 CHAIRMAN BEARISON: And that was rule
14 64B8-9.0092.

15 MR. MCPHERSON: Right.

16 CHAIRMAN BEARISON: Entitled, "The Approval
17 of Physician Office Accrediting Organizations."

18 MR. MCPHERSON: Right. Does everybody have
19 that for reference?

20 CHAIRMAN BEARISON: Great.

21 MR. MCPHERSON: Okay.

22 CHAIRMAN BEARISON: That's just another
23 example of how great this staff is. Everything
24 is here, ready, identified and out for the
25 public. So thanks, again.

1 MR. MCPHERSON: Now, it was Mr. Tellechea
2 suggested that we do that.

3 CHAIRMAN BEARISON: I thought it was yours
4 Larry.

5 MR. MCPHERSON: Members and the public,
6 there are written materials that have been
7 provided on the accreditation issue. We have
8 materials from AAAASF in Book 1, Tab 11. From
9 AAAHC, Book 1, Tab 12. From CARF, Book 2, Tab
10 13. From IMQ, Book 3, Tab 14. The Joint
11 Commission, Book 2, Tab 15. American Academy of
12 Pain Management, Book 2, Tab 16. And
13 additionally they sent their materials which is
14 as a handout. And then something from ISA, Book
15 2, Tab 23.

16 So having said that, I've just shuffled the
17 cards here in no particular order. Dr. Cordner
18 (ph), I see your speaker card. Did you wish to
19 speak on the accreditation?

20 DR. CORDNER: (Not using microphone.)

21 MR. MCPHERSON: I have attorney Anna Small
22 from Broad and Cassel. Did you wish to speak on
23 the accreditation issue?

24 MS. SMALL: (Not using microphone.)

25 MR. MCPHERSON: Okay. We'll go through

1 these again for the second part.

2 We have Mr. Chris Nuland. You're down for
3 prescription.

4 MR. NULAND: (Not using microphone.)

5 MR. MCPHERSON: Only. Okay.

6 Mr. Sloan, did you wish to speak on the
7 accreditation issue?

8 MR. SLOAN: (Not using microphone.)

9 MR. MCPHERSON: Okay. Thank you.

10 Mr. Sloan, I think -- did you provide any
11 written material on this one?

12 MR. SLOAN: No.

13 MR. MCPHERSON: Okay.

14 THE REPORTER: Please raise your right
15 hand.

16 Do you swear or affirm that the testimony
17 given here today will be the truth, the whole
18 truth and nothing but the truth?

19 MR. SLOAN: I do.

20 I didn't supply one of these, but AHCA
21 licensed and risk managed, and I just want to
22 show you the policy and procedures not only for
23 risk management, but for AAAHC.

24 (Not using microphone.)

25 THE REPORTER: Mr. Sloan, you may want to

1 speak in the mic so it's being recorded.

2 MR. SLOAN: Okay. These are my policies
3 and procedures and they're not duplicates. This
4 all requires AAAHC and risk management.

5 CHAIRMAN BEARISON: Is there a bottom to
6 that box?

7 MR. SLOAN: I had to go buy this box
8 yesterday.

9 This is what I need to do for AAAHC and for
10 my risk management, actually I've done most of
11 it. The red book is what we call our felony
12 book.

13 CHAIRMAN BEARISON: Can you just speak up a
14 little because they're recording this.

15 MR. SLOAN: This is the red book which is
16 the AHCA book, the DOH book. We call it the
17 felony book because most of the stuff if you
18 violate is a felony. But this is all policies
19 and procedures for AAAHC and for risk management
20 of a pain clinic.

21 And it's a lot of stuff. I'm not even
22 finished reading all of it and implementing all
23 of it. The majority I have, but that's why I
24 support the AAAHC because it's part of the risk
25 management program. And I've spent \$7,000 from

1 my clinics on risk management.

2 That's really all I have to say is between
3 the American Academy of Pain Medicine or Pain
4 Management and AAAHC, this gets me accredited.
5 And another probably 6 or \$7,000 per clinic, but
6 this is my submission for the agency or AAAHC --
7 excuse me AAAHC.

8 I really don't have a lot more to add
9 except that that's a lot of books. But if you
10 have questions on all this stuff --

11 CHAIRMAN BEARISON: Dr. Tucker?

12 DR. TUCKER: Let me make sure I understood.
13 If he's accredited then he doesn't have to have
14 the annual inspections.

15 AUDIENCE MEMBER: (Not using microphone.)

16 DR. TUCKER: Okay.

17 MR. SLOAN: Right. If you -- which ever
18 agencies you approve for accreditation --

19 DR. TUCKER: Okay.

20 MR. SLOAN: I've asked for AAAHC and
21 American Academy of Pain Management because
22 those two would require all this.

23 DR. TUCKER: Okay. Thank you.

24 MR. SLOAN: And they also work in sync with
25 the risk manager the State of Florida License

1 Risk Manager.

2 CHAIRMAN BEARISON: Mr. McPherson?

3 MR. MCPHERSON: Mr. Sloan, could you
4 summarize what that agency does when they come
5 to one of your clinics? The types of things
6 they look at.

7 MR. SLOAN: Well, they look at all your
8 policies and procedures and I mean, everything
9 from -- here let me just go through this red
10 book. You know, things that you've even set up
11 which are natural disaster plans, evacuation
12 plans, cleanliness, infectious control, waste
13 management.

14 They do a complete survey, I believe
15 they're usually there -- the risk manager was
16 there for a day in each clinic, and I believe
17 AAAHC is there for two days. And I haven't gone
18 through the AAAHC yet, but it's a rather
19 significant survey of the clinic.

20 They go through your charts, your record
21 keeping, your forms, adverse incidents, all
22 that. I mean, it -- it's the same or similar to
23 what you set up for level one or level two and
24 three surgical centers which I believe AAAHC is
25 set up for.

1 So it's basically, yeah, risk -- well, risk
2 manager does the risk management assessments,
3 but I guess AAAHC also oversees the risk
4 management assessment. I mean it's -- for a
5 self-paying clinic, it's a lot of stuff to get
6 done. And you know, things like equipment our
7 EKG machines have to go through annual testing,
8 certification, so on and so forth.

9 CHAIRMAN BEARISON: Dr. Tucker and then
10 Dr. Rosenberg.

11 DR. TUCKER: I just have a question and I'm
12 not sure who to direct this to. I presume that
13 AAAHC is nationally recognized.

14 MR. SLOAN: Right. And I think they're
15 here representing themselves here.

16 DR. TUCKER: Okay. And the American -- the
17 other one that you supported was American
18 Academy of Pain Management.

19 Are they nationally recognized.

20 MR. SLOAN: I believe they -- I don't know
21 what national -- they'll let them answer all
22 those question themselves.

23 DR. TUCKER: Okay.

24 MR. SLOAN: But they are the -- the
25 American Academy of Pain Management has been

1 doing specifically pain clinics and pain offices

2 --

3 DR. TUCKER: Uh-huh.

4 MR. SLOAN: -- since 1988. That's been --
5 so they probably have the longest history of
6 setting up accredited pain clinics than anybody
7 else.

8 DR. TUCKER: Okay. Thank you.

9 MR. SLOAN: (Not using microphone.)

10 DR. ROSENBERG: Well, if AAAHC is here, I'd
11 rather ask them the questions.

12 MR. SLOAN: Yeah, that's agreed.

13 DR. ROSENBERG: Thank you.

14 CHAIRMAN BEARISON: Dr. Rose?

15 DR. ROSE: This is a question for review.
16 If -- the state comes in and does the
17 evaluations on an annual basis, correct? Any
18 other agency that we deem to have the authority
19 to do it, they would also have to do it on
20 annual basis. Only what on their current cycle
21 is. And the report of all other findings are
22 reportable to the Department.

23 MR. MCPHERSON: That is what we would
24 expect this Committee to recommend in the rule
25 before they would accredit someone that they

1 would do that. Yes, sir.

2 DR. ROSE: And we have specific
3 requirements that have been mandated either by
4 rule or the law that those agencies who we
5 decide to inspect for us or accredit the bodies
6 would have to agree to inspect for that may be
7 probably in most cases the same, but there could
8 be some things that are different than what
9 they're normally doing in the course of
10 inspecting his business.

11 MR. MCPHERSON: Yes, sir.

12 MR. SLOAN: The other thing is and part of
13 your rules already that risk management reports
14 are required to be given to the State and you
15 have to abide by them. The State has the right
16 to review them. And they have to be kept on
17 file.

18 CHAIRMAN BEARISON: Mr. Tellechea, did you
19 want to say something?

20 MR. TELLECHEA: Yeah. If you -- I
21 encourage you all to take a look at these -- the
22 rules on office surgery 9.0092 approval position
23 office of accrediting organizations that have
24 been handed out to you. This was written as
25 part of -- well, at the end of a long arduous

1 process when the Board of Medicine had problems
2 with one accrediting agency that we were
3 involved in lots of litigation.

4 And I think it addresses some of those
5 issues that you've already raised, Dr. Rose.
6 The language in here of course it's not all
7 going to be strictly applicable to pain clinics
8 because, you know, it deals with office surgery,
9 but some of the generalized requirements in
10 there regarding, you know, what their standards
11 have to be and how long they are accredited and
12 the responsibilities to the department and all
13 that is in that rule in there, especially on the
14 last page of the rule. That's just some general
15 stuff that I think could be applicable to the
16 circumstances too.

17 CHAIRMAN BEARISON: Okay. Thank you.
18 Ms. Sanford, just wanted to clarify. This
19 organization are they approved to do inspections
20 for the office surgery now?

21 MS. SANFORD: Yes.

22 CHAIRMAN BEARISON: Right. So they're
23 currently doing that. Okay. And how about the
24 other organization? Do you know? That
25 Mr. Sloan mentioned. What was the other one,

1 Mr. Sloan?

2 MR. SLOAN: American Academy of Pain
3 Management --

4 CHAIRMAN BEARISON: No, they're not. But
5 they're not accredited as far as the office
6 surgery.

7 MS. SANFORD: No.

8 CHAIRMAN BEARISON: Okay.

9 MR. TELLECHEA: The ones that are
10 nationally accredited organizations that are
11 approved are AAAASF, AAAHC, JACO and then the
12 Board of Medicine has also approved IMQ.

13 MS. SANFORD: IMQ, yes.

14 MR. TELLECHEA: And that's for the office
15 surgery, correct?

16 MR. MCPHERSON: I should have brought the
17 -- there's a parallel rule for osteopathic
18 medicine. Have they -- is there a -- do we have
19 that?

20 VICE-CHAIR BURNS: Yes. Our rule also
21 includes those entities plus the AOA and HFAP
22 which is a Healthcare Facilities Accreditation
23 Program.

24 MR. MCPHERSON: Okay. Thank you, Doctor.

25 MR. SLOAN: Just remember that the only one

1 is the American Academy of Pain Management is
2 specifically to pain clinics and always has
3 been. It doesn't do anything else but pain
4 management and has for 20 years, I guess.

5 MR. MCPHERSON: Okay. Is there any other
6 Committee members have questions for Mr. Sloan?

7 DR. ROSE: How often are you inspected?
8 How often is your review?

9 MR. SLOAN: Well, my risk management is
10 annually and they're under contract. I have not
11 yet applied for the AAAHC. I just did the risk
12 management and now begin the process of
13 implementing everything and doing my AAAHC. I
14 think they are biannually, but they're here and
15 they'll be able to answer all the questions in
16 detail. I'm just still getting ready for it.

17 CHAIRMAN BEARISON: Very well. Thank you
18 very much for your concise presentation.

19 Mr. McPherson?

20 MR. MCPHERSON: Dr. Tracy, I see your card,
21 but you have -- you wish to speak on the script
22 issue.

23 DR. TRACY: (Not using microphone.)

24 MR. MCPHERSON: Charles Chase, Florida
25 Society of Anesthesiologists, do you wish to

1 speak on accreditation?

2 DR. CHASE: Yes, sir.

3 MR. MCPHERSON: Okay.

4 CHAIRMAN BEARISON: Sir, be sworn in.

5 THE REPORTER: Please raise your right
6 hand. Do you swear or affirm that the testimony
7 given here today will be the truth, the whole
8 truth and nothing but the truth?

9 DR. CHASE: Yes.

10 THE REPORTER: Thank you.

11 CHAIRMAN BEARISON: If you can just give us
12 a little bit about who you are and who you
13 represent and go from there please.

14 DR. CHASE: Good morning. Thank you. I'd
15 like to thank the Board for allowing me to speak
16 this morning. My name is Charles Chase. I'm
17 the vice president of the Florida Society of
18 Anesthesiologists. I'm here representing my
19 society and especially Raphael Miguel who's
20 worked tireless hours on this issue.

21 Our position on the accreditation
22 organizations is that we would recommend only
23 approving those organizations that are also
24 approved by CMS which would be the Joint
25 Commission, AAAHC and the AAAASF.

1 The reason for this is after having gone
2 through office based surgery regulations, we
3 found that overnight organizations were cropping
4 up that reported to be national accrediting
5 organizations and they did their job random,
6 casually and ineffectively. And many of these
7 organizations disapproved no one.

8 So after going through the organization
9 being, you know, kicked out and not being
10 allowed to do accrediting anymore, what we've
11 found is that those organizations already
12 approved by CMS seem to be the ones that are
13 most reasonable in allowing the Board's
14 discretion on this issue.

15 CHAIRMAN BEARISON: Thank you, sir.
16 Mr. Tellechea?

17 MR. TELLECHEA: I hate to disagree with you
18 on this, but that's not true. It was one
19 organization. It was called the Florida Academy
20 of Cosmetic Surgery, and it was only a statewide
21 organization that came up.

22 And the reason I'm familiar with this is
23 because I'm the one who litigated both of the
24 cases when it went to DOAH twice when they were
25 disapproved. So there was only one organization

1 that popped up other than the national
2 organizations and once that one went away, you
3 know, once we tried both those cases at DOAH and
4 they were disapproved both times, they went
5 away.

6 DR. CHASE: I see.

7 MR. TELLECHEA: So there wasn't a
8 proliferation of any entities popping up
9 claiming to be national organizations wanting to
10 be accrediting agencies for the Board. We've
11 only dealt with that one entity.

12 DR. CHASE: Are you familiar with the
13 Florida Association of Inspectors?

14 MR. TELLECHEA: Never dealt with them.
15 They've never been approved by the Board. They
16 haven't even applied to be approved by the
17 Board.

18 DR. CHASE: Okay.

19 CHAIRMAN BEARISON: Committee members?

20 Dr. Tucker, did you want to say something?

21 DR. TUCKER: I just -- you mentioned AAAASF
22 and AAAHC were CMS approved. JACO -- I thought
23 JACO was as well.

24 DR. CHASE: Well, JACO is Joint Commission.
25 They changed their name.

1 DR. TUCKER: But are they -- they're CMS
2 approved.

3 DR. CHASE: Yes.

4 DR. TUCKER: Okay. All right.

5 CHAIRMAN BEARISON: Okay. Thank you, sir.
6 Oh, Mr. Tellechea.

7 MR. TELLECHEA: I just want to say one
8 thing. When we go over these entities and we
9 decide who needs to be approved and who not
10 needs to be approved, just by saying that
11 they're CMS approved -- I mean, I don't, you
12 know, that's not going to get us where we need
13 to go.

14 DR. CHASE: Right.

15 MR. TELLECHEA: Because if we're just going
16 to say that we're going to approve people
17 because they're CMS approved, we need to say
18 why. You know, it needs to give some type of
19 standard for it because otherwise, you know, if
20 you approve everyone that's CMS approved then
21 other people that are not CMS approved and they
22 start challenging that, you know, you're going
23 to have an arbitrary compreciousness issue
24 coming up.

25 Just saying CMS approved is not good

1 enough. You need to say why the CMS approved
2 people or the entities are the best entities. I
3 just encourage you to take a look at that.

4 CHAIRMAN BEARISON: Well, thank you for
5 those comments.

6 DR. CHASE: Thank you, sir.

7 CHAIRMAN BEARISON: Mr. McPherson, next up.

8 MR. MCPHERSON: Dr. Natal. Did I pronounce
9 that right? Natel, Natal?

10 DR. NATAL: Yes, that is correct.

11 MR. MCPHERSON: With the American -- the
12 American Academy of Pain Management. Did you
13 wish to speak on this issue?

14 DR. NATAL: (Not using microphone.)

15 MR. MCPHERSON: Okay.

16 DR. NATAL: Good morning, everyone. We
17 have a power point presentation.

18 (Unintelligible.)

19 CHAIRMAN BEARISON: Christy, this was the
20 organization I had given approval?

21 DR. NATAL: Yes. Yes, sir.

22 CHAIRMAN BEARISON: Okay. And if you could
23 limit the presentation to about 10 minutes or so
24 and then that way it'll leave us time for
25 questions.

1 DR. NATAL: We'll--

2 CHAIRMAN BEARISON: Otherwise people --

3 DR. NATAL: I think we were told 15
4 minutes, but we'll really try to keep it --

5 CHAIRMAN BEARISON: Okay. We appreciate
6 it.

7 DR. NATAL: -- real fast.

8 CHAIRMAN BEARISON: Otherwise, after the
9 first 10 or 12 you may need to pass out popcorn.

10 DR. NATAL: We'll tell jokes and make it
11 fun.

12 (Pause in proceedings.)

13 THE REPORTER: Can you raise your right
14 hand? Do you swear or affirm that the testimony
15 you give here today will be the truth, the whole
16 truth and nothing but the truth?

17 DR. NATAL: I do.

18 CHAIRMAN BEARISON: Are you all ready?

19 DR. NATAL: Yes. Sorry for the delay.

20 CHAIRMAN BEARISON: Do you need the lights
21 down?

22 MR. HUSEMAN: No. That's fine.

23 CHAIRMAN BEARISON: If you can please
24 identify yourselves when and we get started.

25 MR. HUSEMAN: Thank you. My name is Rusty

1 Huseman. I serve as general counsel for the
2 American Academy of Pain Management. I'm
3 honored to be here before this Board again, and
4 we've seen you on many occasions.

5 This morning before I turn it over to our
6 speakers, I would like to make this one clear
7 distinction that as Mr. Tellechea, Ed --

8 AUDIENCE MEMBER: Ed.

9 MR. HUSEMAN: Thank you. I've said it
10 wrong. I've spelled it wrong. Has said there
11 is a distinction between the office surgery rule
12 and this pain clinic rule. And there are two
13 distinct interview, accreditation and inspection
14 processes here, and that's one thing the Board
15 needs to keep in mind when we're talking about
16 this.

17 We need to have as someone -- the Boards
18 need to have as someone who is going to add
19 value to not only to the rule, but also to the
20 Boards in this process. So what you're going to
21 hear from us this morning are basically three
22 themes. The legacy of the American Academy
23 which has a long history as you've already kind
24 of heard about. The fact that we're outcome
25 driven aimed at improving patient quality. And

1 number three we take a consultative approach or
2 depending on what part of the country you're
3 from a consultative approach on the
4 accreditation and inspection.

5 And we do that because we believe that
6 there's more to pain management than just the
7 administration of opioids. That it's an
8 interdisciplinary process and that by taking a
9 consultative approach to this process, the
10 educational process, we can ensure that a) the
11 pain mills we don't want are gone and that the
12 good businesses, the good practices that remain
13 are doing an excellent job. They're not only
14 following the rule, but they're treating our
15 patients well.

16 And that's what this Board is charged to
17 do, both Boards in fact, is patient safety. So
18 with that, I'll turn the mic over to Lennie
19 Duensing the executive director of the American
20 Academy of Pain Management.

21 MS. DUENSING: Good morning. And I thank
22 you for this opportunity to present our pain
23 program accreditation. I know that I'm not a
24 new face to you or getting to be -- to be very
25 familiar faces to one another.

1 Just, again, I've said this before at past
2 meetings and I've been to every meeting since a
3 year ago August, to the hearings and to the
4 workshops. The American Academy of Pain
5 Management is an organization that's been around
6 since 1988.

7 It has always been, since it's inception,
8 interdisciplinary and multidisciplinary because
9 as Rusty just said we have the -- we hold the
10 belief, I mean, we know that pain is very
11 complex and it needs to be completed through a
12 multimodal way of care. We are integrative
13 meaning that we are patient centered. We're
14 evidence based and we bring together all
15 modalities necessary to treat pain.

16 The Academy has -- is the largest pain
17 management organization. We have 5,000 members.
18 About 60 percent are physicians, DOs and MDs.
19 In the last years because of this terrible rise
20 and the diversion and abuse of opioid
21 analgesics, we've focused a lot of our education
22 not just on how to prescribe but on risk
23 management.

24 And I think this is really what we're
25 looking at here in Florida. It's not just

1 general education or looking at -- looking at
2 what doctors need to know about these drugs.
3 The specific education that they need and what
4 we're look at as we're going into clinics here
5 in Florida and all over the country is how well
6 they're managing the risks associated with these
7 medications.

8 You know, we know that they're extremely
9 valuable for many patients, but they're not
10 called controlled substances for nothing. So
11 that's part of our work and I would like to
12 introduce you to, to talk more specifically
13 about our pain program accreditation, my two
14 colleagues, Dr. Bianca Natal and Dr. Larry
15 Short.

16 So I'll turn it over to our new PPA
17 director who has just come on in the last couple
18 of weeks. So Dr. Natal?

19 DR. NATAL: Good morning, everyone. I'm
20 Dr. Maria Bianca Natal. I'm a clinical
21 psychologist and a retired United States Army
22 Medical Service Corp Officer. I am the newest
23 member of the American Academy of Pain
24 Management, and I serve as the director of the
25 pain program accreditation.

1 The pain program accreditation has been the
2 industry leader providing direction and
3 specifically meeting the clinical and
4 organizational needs of pain management
5 facilities. PPA has demonstrated track record
6 in developing and standardizing pain management
7 practices for nearly two decades. I say again,
8 two decades.

9 Pain program accreditation's mission is to
10 provide pain management practices with a
11 framework of evidence based guidelines to ensure
12 optimal patient care. Pain program
13 accreditation is a voluntary program -- okay.
14 This is not in order. Okay.

15 Pain program accreditation requires
16 facilities to meet five categories of standards.
17 These standards are organizational purpose and
18 operations. This addresses policies and
19 procedures that our mission specific -- mission
20 statement address the population being served
21 client demographics.

22 Business practices. Dealing with business
23 plans and addressing patient care policies,
24 legalities, liability, et cetera.

25 Personnel management. Dealing with

1 position descriptions, job descriptions,
2 competency, personnel files.

3 Physical safety. Dealing with the health
4 and safety of facilities to include OSHA,
5 meeting OSHA and ADA requirements.

6 Clinical operations. Dealing with every
7 aspect of the clinical documentation of patients
8 records, eye treatment plans, patient
9 involvement and input. The patient's needs
10 being determined.

11 Dr. Short?

12 DR. SHORT: My name is Dr. Larry Short and
13 I am a professional counselor. I'm also 22
14 years retired Air Force and during that period,
15 I had -- I guess the word would be pleasure --
16 of working with the Air Force Medical IG on a
17 couple of processes. So I'm very familiar with
18 the Attila the Hun model of survey of
19 operations.

20 The Academy's normal process is not that,
21 however. The PPA is a voluntary program. It
22 focuses on organizations who really want to be
23 the very best that they can be both in terms of
24 patient services as well as scope of services.

25 To be eligible for survey with our

1 organization, the program must have been
2 operational for at least six months although
3 generally speaking, organizations are
4 operational for about 24 months before they even
5 apply.

6 They must commit fully to a -- to the
7 process at the patient service level, at the
8 medical direction level and at the executive
9 level, perform an extensive self-assessment
10 across the five categories of standards that we
11 just covered a second ago.

12 And of course also document that they are
13 in compliance with any state or local laws or
14 regulations that would govern their operation in
15 their particular areas.

16 Accreditation really validates four things
17 about administrative and patient care. And
18 basically here are those four.

19 First of all the operations are conducted
20 in a consistent and standardized way. Second
21 that they're driven by policies and procedures
22 and the process that we follow is very much
23 policy and procedure driven. That they are
24 compliant with regulatory requirements. And
25 that they are accountable to produce quality

1 outcomes and to produce patient care that is
2 definable in terms of assisting the patient with
3 his or her pain issues.

4 Now this particular approach provides a
5 feedback loop, if you will. That consists of
6 policies which determine what is done.

7 Procedures which discuss how those things are
8 done. Documentation that proves that those
9 things are done. And outcome measures which
10 show how well those things are done.

11 And when you put these four things
12 together, it results in a recurring process that
13 not only improves patient outcomes, but also
14 improves organizational effectiveness. It also
15 provides an educational framework which
16 organizations may, at their discretion, use to
17 either establish a broader referral base or to
18 extend their catchment areas.

19 In addition AAPMPPA program provides
20 initial assessment and ongoing consultations
21 throughout the accreditation period, not just at
22 survey time. It provides onsite monitoring
23 initially and it is required or requested during
24 the three year period. It is a value even in
25 terms of focusing on policies and practices and

1 feedback on those issues.

2 It is focused on outcomes measurement
3 includes use of a pain outcomes profile which is
4 an instrument developed by the Academy
5 specifically for the purpose of measuring pain
6 treatment outcomes. Clinical survey teams of
7 either one or two individuals depending on the
8 needs of the organization certified.

9 As we mentioned, it's a three-year
10 accreditation cycle with annual reviews which
11 include submission of documentation, phone
12 conferences and follow-up visits if those seem
13 to be required. And of course all this comes
14 complete with membership in the Academy along
15 with access to other Academy services.

16 This process is provided in a very
17 cost-effective way. With the fee structure is
18 as you see there in front of you that really
19 comes out to really a little less than \$5,000
20 from initial application through completion of
21 the survey process.

22 DR. NATAL: In summary, I hope that you
23 have taken a look at some of the letters from
24 our facilities. I think that they show the
25 level -- the quality of care that, you know, the

1 quality of service that we do provide.

2 I believe that the Academy can provide
3 value-added benefits to these Boards of Medicine
4 and reduce, you know, reduce the problems that
5 are happening with our pill mills and provide
6 better patient care for the people in pain who
7 are suffering.

8 So we thank you very much for giving us
9 this time. We welcome any questions.

10 DR. SHORT: Is anybody still awake?

11 CHAIRMAN BEARISON: Well, thank you very
12 much for keeping within the time limit.

13 Dr. Burns.

14 VICE-CHAIR BURNS: Could you speak on the
15 training or the credentials of your surveyors?

16 DR. SHORT: The surveyors are individuals
17 who are themselves a part of an accredited
18 organization either in a administrative or a
19 clinical capacity. They are -- if they are
20 clinical, they are generally trained at the
21 doctor level within their specialty. Since the
22 Academy uses multiple specialties we do stay
23 within those.

24 They generally have an area of expertise
25 that carries through with the consultative model

1 of the accreditation process. So they are both
2 experienced clinicians as well as experienced
3 surveyors. We do have a process of surveyor
4 training that we go through and emphasizes both
5 the standards based and the consultative base of
6 the program.

7 VICE-CHAIR BURNS: Who currently recognizes
8 the PPA?

9 DR. SHORT: The PPA is not recognized by an
10 organizational body that I know of.

11 DR. NATAL: It's just that we've been doing
12 it for -- we keep repeating. It's been going on
13 for 20 years.

14 VICE-CHAIR BURNS: Right.

15 DR. NATAL: There's some insurance
16 companies that accept it and it's changing in
17 it's meaning. For years organizations have used
18 PPA to improve their business, to improve their
19 clinical practices. What's happening now that
20 we're finding more and more around the country
21 is that because of what's happening with a rise
22 in the diversion of use of opioids, they're
23 using it to demonstrate to their communities, to
24 their peers and to regulatory bodies that they
25 have gone through a very rigorous process.

1 It is a very rigorous process. And I would
2 ask you to contact any of our facilities to find
3 out.

4 VICE-CHAIR BURNS: Specifically --

5 DR. SHORT: Actually, just one more thing I
6 might add to that. There have been two
7 insurance companies, Aetna and Cigna, which have
8 recently negotiated -- renegotiated contract
9 with our accredited organizations. They look
10 very closely at the accreditation process and
11 determined that it was acceptable to meet their
12 needs.

13 VICE-CHAIR BURNS: Do you have any
14 recognition by NCQA?

15 DR. SHORT: No.

16 VICE-CHAIR BURNS: Any recognition by
17 ACGME?

18 DR. NATAL: No.

19 VICE-CHAIR BURNS: Any recognition by any
20 State Department of Health?

21 MR. HUSEMAN: Once you decide to elect us
22 as part of your selection --

23 DR. SHORT: There would be one.

24 VICE-CHAIR BURNS: And when you base your
25 quality standards, do you use any national

1 standards such as National Quality Forum or
2 other entities, if you could specify?

3 DR. SHORT: The standards are based on
4 existing standards within the field as well as
5 standards of organizational assessment. So,
6 yes, those types of things are used. And the
7 standards are reviewed and revised every three
8 years.

9 VICE-CHAIR BURNS: Okay.

10 CHAIRMAN BEARISON: Dr. Tucker?

11 DR. TUCKER: Let me make sure I understood.
12 Thus far you're accreditation has been
13 voluntary; is that correct?

14 DR. SHORT: That is correct. It is an
15 entirely voluntary process.

16 DR. TUCKER: Can you give me -- and this
17 may be a very difficult question to answer, but
18 can you give me a percentage of Florida pain
19 management practices that have been accredited
20 by your agency?

21 DR. SHORT: We currently have five
22 accredited programs in Florida.

23 DR. TUCKER: Five out of thousands? No?

24 DR. SHORT: I don't know.

25 DR. TUCKER: I mean, you didn't say five

1 percent. You mean five total.

2 DR. SHORT: Five total. That's correct.

3 DR. TUCKER: Okay.

4 DR. NATAL: For the purposes of answering
5 right now -- for the purposes of answering your
6 question immediately, we can't provide that
7 information, but I think what Dr. Short is
8 saying is that currently there are five
9 accredited agencies in Florida. That doesn't
10 mean that since the inception of PPA and the
11 accrediting process that there's only been five.
12 We can get back to you with that information.

13 DR. TUCKER: That would be helpful.

14 CHAIRMAN BEARISON: Dr. Rose?

15 DR. ROSE: Nationally, how many programs
16 does your organization inspect a year?

17 DR. SHORT: We currently have 51
18 accredited. We have 24 that are in the process
19 of actively preparing to get accredited.
20 Generally speaking, the number of accredited per
21 year will range anywhere from 15, probably on
22 the low end -- and my experience -- I've been
23 involved with the program since 1991. So
24 generally from 15 to about 22.

25 DR. ROSE: Are those -- that includes both

1 the first time applicants to become accredited
2 and/or reinspections or renewals?

3 DR. SHORT: That is correct.

4 DR. ROSE: How many of those are
5 approximately are first time applying to be
6 accredited by your organization?

7 DR. SHORT: Approximately 40 percent.

8 DR. ROSE: 40 percent?

9 DR. SHORT: The --

10 DR. ROSE: And of those 40 percent how many
11 of them pass on the first time without any
12 corrections they need to do and then about how
13 many need to come back and find some minor
14 changes and how many out and out just fail it?

15 DR. SHORT: Well, historically about 90
16 percent. Basically the organizations are
17 provided with the standards. This is not really
18 a pop quiz. So there's nothing secret about
19 this at all. If the organization does the
20 self-study and does that adequately, our
21 organizations tell us often times that's the
22 most useful part of the process. It allows them
23 to --

24 MR. MCPHERSON: Excuse me, sir. Can you
25 speak in the microphone? I'm having a difficult

1 time hearing you.

2 DR. SHORT: -- which -- our organizations
3 tell us that the self-study processes is really
4 often times the most helpful part of the
5 process. Because it allows them to take a look
6 at themselves and to discuss those issues among
7 themselves. The organizations that really don't
8 complete the survey are those that decide for
9 some reason they don't want to put the effort
10 into it or simply do not prepare adequately.

11 So we do have a one year provisional and
12 then the Board of Directors of course is the
13 deciding body in this regard and certainly they
14 can decide to deny the accreditation completely.

15 DR. ROSE: How many days does the
16 inspection process last on site?

17 DR. SHORT: At present the survey process
18 is a one-day process.

19 DR. ROSE: And can you construct out the
20 organization relationship between the American
21 Academy of Pain Management and this particular
22 entity that's doing the accreditation -- are you
23 one in the same? Because I see the same people
24 here on both things and how is that
25 organizationally and is there -- could there be

1 potential conflicts between one group that's
2 certifying people and pain and also on the other
3 hand inspecting them? Is that part of the same
4 agency or a related agency?

5 Mr. Huseman: Let me try to address that.
6 American Academy of Pain Management if it would
7 be responsible for inspecting any of its own
8 members, it has a standard of the rule that the
9 Boards will adopt. And that rule is going to be
10 set down and I'm suspecting that as we've done
11 before, the criteria will be set and the entity
12 that you select to assist in these
13 accreditations and inspections are going to have
14 to meet at a minimum that criteria.

15 So it's not going to be a choice of whether
16 or not we like or we dislike or they're a member
17 or not a member. Because that's where as Ed was
18 saying before that's where some potential
19 problems and conflicts get in.

20 DR. ROSE: And who oversees your
21 organization? Some people talked about if you
22 were nationally recognized or whatever. Is
23 there -- what Board overlooks your whole
24 process? In other words, who inspects the
25 inspectors to make sure that you all are living

1 up to the top quality as an inspection
2 organization yourself? Are there national
3 groups that you could be reviewed by or
4 accredited by that says you're doing things that
5 are the standard of inspections for inspecting
6 bodies or not?

7 DR. NATAL: No -- we don't. We don't. I
8 mean, if you want to know how it's structured,
9 the -- again, since -- almost since the
10 beginning of the American Academy of Pain
11 Management we have a service that's called pain
12 program accreditation.

13 The way that it's run is that we have a
14 committee consisting of -- there's a -- we have
15 a director. We have other staff members. We
16 have the survey team. Dr. Short is actually the
17 trainer and has been for a long time of the
18 surveyors. It's a very rigorous process. We
19 don't go into places without taking -- I mean,
20 this is something that we take very seriously.

21 The board of directors of the Academy
22 ultimately oversees and makes as Dr. Short's,
23 certain decisions when it comes to when there
24 are questions. The decisions and the way that
25 we move forward is through -- through various

1 processes that the Committee takes on along with
2 the director.

3 Is that explaining it to you? But we don't
4 have -- there's not like -- we don't have
5 another agency. There's not another agency
6 that's approved us.

7 Again, we understand that right now, things
8 are very different. You know, this was
9 something that we -- that facilities and clinics
10 gain great benefit from and we hear it one after
11 the other that they've really improved their
12 businesses.

13 Things are different now out in the field
14 and we understand that. You know, and we
15 understand that there -- the standards are
16 changing.

17 CHAIRMAN BEARISON: I want to kind of wrap
18 this up, but I know Dr. Rosenberg had his hand
19 up and I think Dr. Burns did.

20 DR. ROSENBERG: I was just curious. Have
21 you applied for accreditation at -- in any other
22 state and been turned down?

23 DR. SHORT: No.

24 DR. ROSENBERG: So this is the first state
25 you're applying for?

1 DR. SHORT: That's correct.

2 CHAIRMAN BEARISON: Thank you. Dr. Burns.

3 VICE-CHAIR BURNS: Just for clarification
4 for other Committee members, I heard in your
5 testimony that you used doctoral level
6 surveyors. Do you use any --

7 DR. SHORT: Within the specialty. There
8 are some administrative surveyors who are not --

9 CHAIRMAN BEARISON: Sir, can you speak in
10 the microphone?

11 DR. SHORT: There are some administrator
12 surveyors who are not doctorally trained.

13 VICE-CHAIR BURNS: In the five facilities
14 that have been inspected and approved here in
15 Florida that you have use the PPA program with,
16 have any of those five had board certified
17 physician surveyors or risk managers approved by
18 the agency for healthcare administration
19 licensed in Florida of surveyors?

20 DR. SHORT: One of the -- one organization
21 had a physician on the survey team. I'm not
22 certain of the background.

23 DR. NATAL: Yes, he was. I know the
24 physician who was on it and he's an
25 anesthesiologist. He's a board certified

1 anesthesiologist.

2 VICE-CHAIR BURNS: So one of the five?

3 DR. NATAL: Yeah.

4 DR. SHORT: Yeah.

5 CHAIRMAN BEARISON: Any other Board
6 members?

7 Thank you very much for your presentation.

8 Mr. McPherson?

9 MR. MCPHERSON: Jennifer Hoppe from the
10 Joint Commission. Did I come close to the
11 pronunciation on that?

12 MS. HOPPE: Yeah, it's Hoppe.

13 MR. MCPHERSON: Ms. Hoppe, okay. Thank
14 you, Ms. Hoppe.

15 THE REPORTER: Do you swear or affirm the
16 testimony you give here today will be the truth,
17 the whole truth, and nothing but the truth?

18 MS. HOPPE: Yes.

19 THE REPORTER: Thank you.

20 MS. HOPPE: Hello. I'm Jennifer Hoppe and
21 I'm the Associate Director for State Relations
22 with the Joint Commission.

23 I know we did submit information on the
24 Joint Commission Standards, our survey process,
25 and then as well as answered about ten questions

1 that the Board submitted for responses.

2 But I wanted to come up. I think --
3 Dr. Rose, I think you had asked a question about
4 the survey reports, obtaining copies of the
5 survey reports earlier in the conversation, and
6 what I wanted to discuss is that, you know, the
7 Joint Commission's policy does not currently
8 allow us to forward survey reports to State
9 agencies.

10 Any time a State agency is recognizing or
11 requiring accreditation, what we recommend is
12 that through regulation that you would state
13 that if the organization, so if the pain
14 management clinic wants to use its accreditation
15 to satisfy the State licensure requirements in
16 lieu of the Department survey, that you would
17 request that they submit a copy of that report
18 to you.

19 We do make the reports available online to
20 the organizations. They can download them any
21 time in a PDF file so they can easily access
22 them and have those available to you either hard
23 copy or email.

24 So that was the one point of clarification
25 that I wanted to make from the Joint

1 Commission's stand.

2 Yes?

3 MR. MCPHERSON: Just a question. Does that
4 mean that if -- if you were to do a survey --

5 MS. HOPPE: Uh-huh.

6 MR. MCPHERSON: The only way the State
7 would know that a survey was done is if that
8 entity sent a copy of the survey to the State;
9 is that right?

10 MS. HOPPE: To get a copy of the report.
11 In terms of knowing if a survey's been done or
12 if an organization is accredited, we have a
13 public website where you can look up the
14 accreditation status of any organization, it's
15 dynamic search engine --

16 MR. MCPHERSON: Understand.

17 MS. HOPPE: -- and you could pull it.

18 MR. MCPHERSON: I guess let me ask it a
19 different way.

20 If you accredited an organization --

21 MS. HOPPE: Uh-huh.

22 MR. MCPHERSON: -- and you later did a
23 survey, either a routine survey or because of a
24 report you got --

25 MS. HOPPE: Uh-huh.

1 MR. MCPHERSON: -- and so you did a survey.
2 How would the State know that you did a survey
3 if the entity didn't send a copy to the State?

4 MS. HOPPE: The one thing that we do make
5 available to the State agencies is the ability
6 to get our survey schedule in a advance.

7 AHCA is actually one where we do also send
8 to them listings of all the surveys that we've
9 conducted. So -- and again, because they
10 recognize us for hospital, ambulatory, home
11 care, et cetera, so we -- we do send them a
12 listing. So I don't know if that's something
13 that you would want to get through them, or if
14 you would want to have that directly sent from
15 the Joint Commission to somebody within, you
16 know, the Department of Health, the Medical
17 Board.

18 MR. MCPHERSON: I think what the Committee
19 wants to hear from any accrediting organization
20 is if we do a survey --

21 MS. HOPPE: Uh-huh.

22 MR. MCPHERSON: -- we're going to tell you
23 we did a survey --

24 MS. HOPPE: Right.

25 MR. MCPHERSON: -- on one of your pain

1 clinics.

2 MS. HOPPE: Uh-huh. Which -- and again, we
3 can do that. Currently, that's the process that
4 we do use with AHCA. We send them a listing of
5 all -- of the surveys that we've done. So we
6 send them --

7 MR. MCPHERSON: And you would do the same
8 for the --

9 MS. HOPPE: We can certainly arrange to do
10 that, yes. But we wouldn't send the copy of the
11 survey findings.

12 MR. MCPHERSON: How often would that be?

13 MS. HOPPE: We do surveys typically on a
14 three-year timeframe, although the Joint
15 Commissions policy is that we can go back and
16 conduct a routine full survey anywhere between
17 18 and 39 months from the last survey.

18 MR. MCPHERSON: But -- let me ask that
19 again.

20 How often do you update your list of
21 surveys? If you did a survey in January --

22 MS. HOPPE: Uh-huh.

23 MR. MCPHERSON: -- of 2011 --

24 MS. HOPPE: Oh, the --

25 MR. MCPHERSON: -- how often --

1 MS. HOPPE: -- the listing that we send to
2 the State agency here in Florida, we send it on
3 a monthly basis.

4 MR. MCPHERSON: Monthly. Thank you.

5 MS. HOPPE: Uh-huh. Yes.

6 CHAIRMAN BEARISON: Dr. Burns?

7 VICE-CHAIR BURNS: As Committee members we
8 hear the word "certified by CMS" thrown around
9 quite a bit.

10 MS. HOPPE: Uh-huh.

11 VICE-CHAIR BURNS: I understand that the
12 Joint Commission is one of only three national
13 voluntary surveyors accrediting organizations by
14 CMS that have the deem status to accredit
15 hospitals and ambulatory centers.

16 Could you comment on that and what that
17 means?

18 MS. HOPPE: Oh, certainly. Obviously with
19 CMS they do have the federal regulations that
20 require anyone for participating in the Medicare
21 program to meet those regulations. And the
22 Joint Commission as well as, you know, a few of
23 our competitor accrediting bodies have gone
24 through the process of applying to CMS and
25 doing, you know, a comparison of the Joint

1 Commission standards to the federal regulations
2 as well as a detail review on the onsite survey
3 process and how that process would align with
4 what a State survey would look like. And so
5 then they deemed the Joint Commission to be -- a
6 deemed accrediting body. So that if an
7 organization is accredited by the Joint
8 Commission, they are automatically deemed to be
9 participating in the Medicare program.

10 VICE-CHAIR BURNS: And there's three
11 current national organizations?

12 MS. HOPPE: Well, no. There are three in
13 terms of ambulatory surgery centers. And when
14 you -- like the other day we were talking about
15 staying in terms of the Joint Commission, AAAASF
16 and AAAHC.

17 VICE-CHAIR BURNS: Where does HFAP fit in
18 there?

19 MS. HOPPE: HFAP is from the hospital side.
20 I don't -- to be honest with you, I don't know
21 if HFAP is approved for ambulatory surgery
22 centers or not. You know, I'm not -- I'll
23 explain that.

24 But in the hospital side they're approved.
25 HFAP is a hospital deeming authority as well as

1 a new accrediting body, DNB, that's come into
2 the mix. About two years ago they were approved
3 for the first time.

4 VICE-CHAIR BURNS: And I'll ask you the
5 same question as the previous one. Who
6 currently recognizes Joint Commission?

7 MS. HOPPE: Well, we're actually
8 recognizing all 50 states for a variety of our
9 accreditation programs for state licensing, for
10 Medicare obviously --

11 VICE-CHAIR BURNS: Uh-huh.

12 MS. HOPPE: -- and then Medicaid
13 reimbursement as well.

14 VICE-CHAIR BURNS: NCQA?

15 MS. HOPPE: We are not accredited through
16 the NCQA, no.

17 VICE-CHAIR BURNS: Okay.

18 MS. HOPPE: They would be on the other
19 side. But we also have, you know, various
20 recognitions throughout, you know, third-party
21 commercial insurance companies --

22 VICE-CHAIR BURNS: Uh-huh.

23 MS. HOPPE: -- in terms of recognizing
24 accreditation or requiring it to be a network
25 participant.

1 VICE-CHAIR BURNS: And do you use other
2 measures to set your measure sets as far as like
3 national quality forum --

4 MS. HOPPE: Yes. Oh, yes. Uh-huh. For
5 performance measurement, yeah.

6 VICE-CHAIR BURNS: Yeah?

7 MS. HOPPE: That's a standard of the Joint
8 Commission.

9 VICE-CHAIR BURNS: Uh-huh. Okay. Thank
10 you.

11 CHAIRMAN BEARISON: Dr. Tucker?

12 DR. TUCKER: I have a problem with your not
13 reporting. What is your rationale that you
14 would not send us your report on the survey?

15 MS. HOPPE: Well, accreditation is a
16 voluntary process. And when an organization
17 applies for accreditation they enter into a
18 contract with the Joint Commission and we do
19 state in that contract that the accreditation
20 report and survey findings are confidential,
21 that it's between the Joint Commission and that
22 accrediting body.

23 DR. TUCKER: Okay. Well, we're not talking
24 about voluntary accreditation anymore. We're
25 talking about places -- well, I mean voluntary

1 versus the annual inspections there.

2 MS. HOPPE: Uh-huh.

3 DR. TUCKER: So -- and we're a primary
4 verification state.

5 MS. HOPPE: Uh-huh. Right.

6 DR. TUCKER: I mean, we don't accept -- I
7 had to get my diploma sent from the school. I
8 had to get my transcript sent from the school.
9 It's not good enough to send it myself.

10 So why do you think you're any different
11 from that?

12 MS. HOPPE: Just to state that those are
13 the policies and terms of the Joint Commission
14 that that's how we handle for all programs in
15 all states and all settings. We can and have at
16 times, you know, gotten a written authorization
17 release from the organization to provide a copy
18 of a report to a State agency; however, we do
19 have to get that authorization and without it we
20 would not be able to do that.

21 At the same time, the Joint Commission is
22 located in the state of Illinois and we have
23 certain protections there under the law. And,
24 again, I'm not a lawyer so I don't know this,
25 but our lawyer speaks to the fact that even we

1 are subpoenaed for copies of our survey report,
2 we are able to, under the law, not provide them.

3 So it is a unique scenario. I could,
4 again, talk with our attorneys and get you some
5 more information in terms of why it is that the
6 Joint Commission keeps survey reports
7 confidential. I don't have that at the time,
8 but I can certainly get that, if needed.

9 DR. TUCKER: And the cost of your
10 accreditation?

11 MS. HOPPE: The average cost for what we
12 would be talking about here in terms of a pain
13 management clinic would range between \$8,000 and
14 \$9,000.

15 However, if it does vary on the size of the
16 organization and as well as if they have
17 multiple sites. So if there's an increase, it
18 goes off of patient volume. So it could
19 potentially be higher. But for your average
20 pain management clinic, it would be between
21 \$8,000 and \$9,000.

22 DR. TUCKER: Okay.

23 CHAIRMAN BEARISON: Dr. Rose and then
24 Dr. Burns.

25 DR. ROSE: So what I'm hearing, if I

1 understand this correctly, since our registered
2 pain management clinics theoretically will have
3 a choice as who they want to inspect, as part of
4 the condition that we can make for their
5 election, if we accept the Joint Commission to
6 allow the Joint Commission to do the inspection
7 or accreditation for them, we could require them
8 on our end to make them sign a full release --

9 MS. HOPPE: Oh, certainly.

10 DR. ROSE: -- a disclosure that any survey
11 that was done --

12 MS. HOPPE: Uh-huh.

13 DR. ROSE: -- that they would give you
14 permission to release all the results to us for
15 as long as they're accredited by your agency.
16 That would be something, I think, as a rule we
17 could make as a condition --

18 MS. HOPPE: If you -- if you had --

19 (CROSSTALK.)

20 DR. ROSE: -- do that.

21 MS. HOPPE: -- we would then in turn still
22 need to get that authorization to release it.
23 And again, on the other side in terms of state
24 licensure, Agency for Health Care Administration
25 does accept the reports from the agencies

1 directly. They don't -- we don't submit them --

2 DR. ROSE: But we would want like some sort
3 of certified copy that it hasn't been altered,
4 manipulated in any way, which is so easily done
5 in the computer age.

6 MS. HOPPE: Uh-huh. Right.

7 DR. ROSE: So we would want that. But I
8 think we could, you know, have some kind of rule
9 that would require if they elect that route to
10 do that, that they would be required to agree to
11 that release for all reports.

12 MS. HOPPE: Uh-huh. Exactly.

13 CHAIRMAN BEARISON: Dr. Burns, did you have
14 your hand up?

15 VICE-CHAIR BURNS: Dr. Rose clarified my
16 question.

17 CHAIRMAN BEARISON: Any other Committee
18 members, staff, any questions?

19 DR. ROSE: The inspectors that go and
20 inspect the facility, do you currently inspect
21 pain facilities now as part of what you do?

22 MS. HOPPE: Yes, we do.

23 DR. ROSE: The inspectors that go there,
24 are they MDs, DOs, are they PhDs? What type of
25 people go in there? And if they are clinicians,

1 MDs or DOs, are they specialty-specific for that
2 situation?

3 MS. HOPPE: Well, we have both physician
4 and masters-prepared nurses in the ambulatory
5 care accreditation program. So it could be
6 either one of those two that would go out and
7 conduct that survey. And while it isn't always
8 a guarantee that they will have experience or
9 background in pain management, we do try to do
10 our best to match up skills with the site that
11 they're surveying.

12 DR. ROSE: Uh-huh.

13 CHAIRMAN BEARISON: Mr. Tellechea?

14 MR. TELLECHEA: I didn't hear that answer.
15 You said they're either physicians or what?

16 MS. HOPPE: Physician or masters-prepared
17 nurses.

18 MR. TELLECHEA: Okay.

19 CHAIRMAN BEARISON: I think somebody had
20 their hand up.

21 Dr. Rosenberg?

22 DR. ROSENBERG: How would you inspect the
23 facility of a brand new doctor just getting
24 started and how much would that cost?

25 MS. HOPPE: Okay. It would be, again, the

1 same fee that they would be -- between \$8,000
2 and \$9,000 because that's for the smallest
3 program in our ambulatory care accreditation
4 program.

5 In terms of initial survey, you're looking
6 for prior to them opening -- I mean --

7 DR. ROSENBERG: Well, he's finished his
8 residency. He wants to start his practice.

9 MS. HOPPE: Okay.

10 DR. ROSENBERG: He has no patients, but
11 needs to be accredited.

12 MS. HOPPE: Oh, he needs to be? Okay.

13 Well, we do have what's known as the early
14 survey option where we would go out twice and
15 conduct a survey. So our first survey -- we'd
16 come out and we'd do it prior to any patient
17 care being conducted, and it's a review of
18 policy and procedures, leadership planning,
19 human resources, that type of thing. So it's
20 all prior to patient care.

21 And at that point, if it's a successful
22 survey, they'd be rendered a preliminary
23 accreditation decision, and then we'd go back
24 out in about four months after they begin seeing
25 patients and conduct a full survey.

1 But, again, that's an option that -- it is
2 utilized when accreditation is required to be in
3 business. For example, home health here in
4 Florida, they have to be accredited prior to
5 being licensed.

6 DR. ROSENBERG: So they really wouldn't get
7 their accreditation for four months because
8 you'd be coming back four months later.

9 MS. HOPPE: The full accreditation,
10 correct. Correct.

11 It's the preliminary accreditation is
12 what's rendered at prior. Because, again, we
13 have to be on our survey. We have to trace
14 patients and trace patient care and assess
15 compliance with the standards of providing care.
16 So we have to have active patients at the time.
17 So we can't render a full accreditation decision
18 prior to patient care being provided.

19 DR. ROSENBERG: Maybe Mr. Tellechea or
20 Mr. McPherson can help me out. How -- how would
21 that work then for a physician who wants to
22 start practice if he needs to be accredited?

23 MS. HOPPE: I believe it's -- it's a
24 recognition of accreditation, not a requirement
25 in your roles.

1 MR. TELLECHEA: I'm sorry. I don't
2 understand the question.

3 DR. ROSENBERG: If it is a new doctor who
4 just finished his residency and wants to open
5 his practice and he needs to be accredited, and
6 they have a four-month delay in accrediting
7 someone, is there a timeframe after a doctor
8 opens their practice -- is there flexibility
9 before they have to be accredited or do they
10 need to have their office accredited right away?

11 MR. TELLECHEA: Well, they would -- in
12 order to practice as a pain clinic they would
13 have to be inspected then by the Department of
14 Health.

15 DR. ROSENBERG: Uh-huh.

16 MR. TELLECHEA: If they get inspected by
17 the Department of Health and they pass the
18 inspection, then they are practicing. And then
19 if they want to they can work on getting
20 accredited by, you know, some accrediting
21 agency.

22 DR. ROSENBERG: (Unintelligible.)

23 MR. TELLECHEA: But they're going to have
24 to meet the minimum standards for operating as a
25 pain management clinic which would be to be

1 inspected to pass the inspection.

2 So that would be the avenue that they would
3 have to take.

4 DR. ROSENBERG: Okay. Thank you.

5 CHAIRMAN BEARISON: Mr. McPherson has the
6 answer.

7 MR. MCPHERSON: Doctor, the statute says
8 they have to be inspected within a year. So if
9 somebody was waiting until the last day of that
10 one year and then said, well, we've applied for
11 accreditation, that might be a problem; that
12 might be an issue.

13 But it's within one year, so there's some
14 --

15 DR. ROSENBERG: Okay. Good. That's fine.
16 Thank you.

17 CHAIRMAN BEARISON: Dr. Winchester, I
18 believe you had your hand up.

19 DR. WINCHESTER: I was just going to
20 comment about the release issues. If you look
21 at the last page of the office surgery
22 accreditation, the very top line, it talks about
23 the accrediting agency shall obtain
24 authorization from the entity to release
25 accreditation report.

1 So if we go back to looking at these rules
2 maybe as a template, it's a requirement in those
3 rules that a release be a part of the agreement.

4 MS. HOPPE: Uh-huh.

5 CHAIRMAN BEARISON: Mr. McPherson?

6 MR. MCPHERSON: Just one last thing. I
7 think I know the answer to this, but as a
8 previous speaker has said, that the -- your
9 organization, when they conduct the initial
10 survey and as they accredit every three years --

11 MS. HOPPE: Uh-huh.

12 MR. MCPHERSON: -- that you, as part of
13 that process, would use the Florida Statutes and
14 the rules of the Boards of Medicine and
15 Osteopathic Medicine --

16 MS. HOPPE: Uh-huh.

17 MR. MCPHERSON: -- in terms of what you're
18 looking for when you conduct that inspection.

19 MS. HOPPE: Correct.

20 MR. MCPHERSON: Is that correct?

21 MS. HOPPE: Correct. And I believe there
22 was a question that was posed in -- to all the
23 accrediting bodies on that, if we would add
24 specific requirements. And we have in the past
25 when states have requirements that for whatever

1 reason go above and beyond the standards, we
2 have an addendum for the surveyors to follow.
3 And then we do have a standard that requires
4 them to be in accordance with law and regs so we
5 can score it at that point.

6 CHAIRMAN BEARISON: Ms. McNulty?

7 MS. MCNULTY: That would include, for
8 example, if the Boards required surveyors to
9 have certain qualifications, you would abide by
10 those?

11 For example, if they needed to be an MD or
12 DO --

13 MS. HOPPE: Uh-huh.

14 MS. MCNULTY: -- or registered --

15 MS. HOPPE: Right. If it was for the -- if
16 you were looking for them to specifically be a
17 physician that was going out and surveying, then
18 that's something we could accommodate. We would
19 have to work through our operations department
20 to make sure that, you know, in Florida when
21 we're doing a pain management clinic that the
22 nurse doesn't get scheduled, but yet, you know,
23 it's a physician.

24 However, if it got more specific in terms
25 of a specific type of physician that's where

1 then obviously, you know, our surveyor pool
2 would get smaller and smaller to pull from, so
3 we would have to look at whether or not we could
4 accommodate that.

5 CHAIRMAN BEARISON: Mr. Tellechea?

6 MR. TELLECHEA: Okay. This may kind of
7 come across as kind of a simple -- simple
8 question, but this was really the heart of the
9 problems that we had when we were dealing with
10 the office surgery or accreditation entities.

11 Will you accredit any facility, prior to --
12 prior to them demonstrating to have 100%
13 compliance with your accreditation standards?

14 MS. HOPPE: No. With the exception being
15 the preliminary accreditation decision that's
16 rendered after an early survey option, the first
17 survey. But we do go back then in the four
18 months and do the full survey.

19 MR. TELLECHEA: How long --

20 MS. HOPPE: But otherwise the accreditation
21 decisions are not rendered until after an
22 organization has submitted their evidence of
23 standards compliance for all noncompliant
24 standards. That's --

25 MR. TELLECHEA: So you'll provisionally

1 accredit them without -- so how long is this
2 provisional accreditation?

3 MS. HOPPE: It's -- I'm sorry. We call it
4 preliminary accreditation.

5 MR. TELLECHEA: Preliminary. I'm sorry.

6 MS. HOPPE: I think each one of the, I
7 think, accrediting bodies have a different term
8 for how we --

9 MR. TELLECHEA: Uh-huh.

10 MS. HOPPE: -- but so from the Joint
11 Commission's perspective it is preliminary
12 accreditation. And again, typically speaking,
13 we'll go back in four months. But if an
14 organization wishes to be surveyed sooner, a lot
15 of times it's we're waiting for them to get the
16 minimum patient thresholds for us to come out --
17 back out and conduct that survey.

18 MR. TELLECHEA: Okay. So you go in there,
19 you survey a facility. They don't -- they're
20 not a hundred percent in compliance; there are
21 some deficiencies. You give them a preliminary
22 accreditation?

23 MS. HOPPE: No. No. When we go out and do
24 a full survey, let's just say with the initial
25 first survey.

1 MR. TELLECHEA: Uh-huh. Okay.

2 MS. HOPPE: The Joint Commission does not
3 have -- has no decision on them. So they
4 wouldn't be accredited or it's just a "never
5 surveyed" in our system.

6 MR. TELLECHEA: Okay.

7 MS. HOPPE: After the survey takes place,
8 if there are any noncompliant standards, which
9 there usually are, the organization has between
10 45 and 60 days, depending on the type of
11 deficiency, to subject evidence of standards
12 compliance --

13 MR. TELLECHEA: Okay.

14 MS. HOPPE: -- to the Joint Commission. If
15 that is accepted and approved at that time, then
16 an accreditation decision is rendered. It is
17 not until then.

18 MR. TELLECHEA: Okay. So basically you're
19 requiring one hundred percent compliance.

20 MS. HOPPE: Correct.

21 MR. TELLECHEA: Okay.

22 MS. HOPPE: Correct.

23 CHAIRMAN BEARISON: Ms. Goersch?

24 MS. GOERSCH: I just want to clarify. So
25 the only difference between the initial survey

1 and the follow-up survey is just a review of the
2 patient records, or is there more?

3 MS. HOPPE: You know, I just want to
4 clarify. That was just -- it's a option for
5 organizations, an initial organization coming
6 into the accreditation fold, to undergo an early
7 survey option.

8 It's a two-part survey. They pay extra for
9 it. It's not a requirement. And really the
10 only time we utilize that survey option is when
11 a state requires accreditation in order to be in
12 business.

13 So, for example, in New York under their
14 office based surgery rules, they require a
15 practitioner using anesthesia to be accredited
16 before they perform that procedure.

17 So, again, it's an avenue for them to come
18 in and get a preliminary accreditation status,
19 which that state does recognize.

20 So it's not -- it's not the norm. Most
21 organizations coming to us would just apply for
22 accreditation and have an initial full survey.

23 MS. GOERSCH: And then the states, like New
24 York, they accept a preliminary accreditation as
25 counting as accredited?

1 MS. HOPPE: Correct.

2 MS. GOERSCH: And that --

3 MS. HOPPE: Pending -- that pending that
4 the full survey takes place within the
5 four-month timeframe and they get -- and they
6 achieve the full accreditation.

7 MS. GOERSCH: Okay.

8 MS. HOPPE: If for any reason there was an
9 adverse accreditation decision from that, we
10 would notify them.

11 MS. GOERSCH: Okay. And again, my first
12 question, the second -- if there's a two part --

13 MS. HOPPE: Uh-huh.

14 MS. GOERSCH: -- the second visit is only
15 to check patient, actual patient records for
16 compliance. Is that --

17 MS. HOPPE: Oh, no. It's a full survey.

18 MS. GOERSCH: It's the whole thing again.

19 MS. HOPPE: It is a full survey. It is a
20 full survey, yes. It is the full survey.

21 MS. GOERSCH: So what -- I guess I'm trying
22 to get to what the difference is on the
23 preliminary survey.

24 MS. HOPPE: The first survey -- in an early
25 survey option, the first survey, there is no

1 patient care being provided, so we're not
2 assessing any of the patient care standards.
3 It's only policies and procedures, environment
4 of care, human resources planning, that type of
5 --

6 MS. GOERSCH: So it's only patient care is
7 the difference; is that -- is that correct?

8 MS. HOPPE: Correct.

9 MS. GOERSCH: Thank you.

10 CHAIRMAN BEARISON: Very well. Thank you
11 very much for your presentation. We can all
12 tell you were well informed and we appreciate
13 your concise and direct answers.

14 And also I understand you traveled from
15 very far.

16 MS. HOPPE: Yeah, from Chicago.

17 CHAIRMAN BEARISON: So thank you very much
18 for coming. Your information was very useful to
19 us.

20 Mr. McPherson?

21 MR. MCPHERSON: Next would be Tom Terranova
22 from AAAASF. You indicated if needed for
23 questions you're available. If nobody has
24 questions, did you wish to speak?

25 MR. TERRANOVA: I just wanted to say

1 something about (not using microphone).

2 MR. MCPHERSON: Okay. Tom Terranova.

3 CHAIRMAN BEARISON: Sir, if you can be
4 sworn in, please.

5 THE REPORTER: Do you swear or affirm that
6 the testimony you give here today will be the
7 truth, the whole truth and nothing but the
8 truth?

9 MR. TERRANOVA: Yes.

10 THE REPORTER: Thank you.

11 CHAIRMAN BEARISON: Sir?

12 MR. TERRANOVA: Hi. I'm Tom Terranova.
13 I'm the Director of Legislative and External
14 Relations for AAAASF.

15 I just wanted to -- I already submitted the
16 standards and all of our program information.

17 The one thing I wanted to say about sharing
18 our report with the State. There's no real
19 barriers as far as Quad-A is concerned with
20 providing that. But one thing I would caution
21 against is that if you, as a body, decide to
22 collect survey reports on every single facility
23 that's done even routine, there's going to be a
24 ton of deficiencies that are carried out in the
25 normal course of the accreditation process.

1 Typically, oftentimes, this is paperwork.
2 So I am not sure that you want all that
3 information. I mean, it's there, but to have --
4 you know, that a facility was missing a hiring
5 policy and they provided one six days later
6 might not be that helpful, but, you know,
7 investigative reports or adverse events, that
8 might be more helpful.

9 That was the only point I wanted to make.

10 CHAIRMAN BEARISON: Committee members, any
11 questions?

12 Dr. Tucker?

13 DR. TUCKER: I guess partial reports, we
14 may not want anything. This is all new to us,
15 so I'm not sure that we know right now what we
16 want and what we don't want. But I'm gathering
17 that you -- your organization is willing to
18 share those reports or report directly to us
19 when you do a survey?

20 MR. TERRANOVA: Well, again, in -- New York
21 and California are the two with really kind of
22 robust reporting already. And we report to them
23 on decisions or on accreditations and surveys
24 carried out on a monthly basis, and our full
25 roster of -- like in New York's case, the full

1 roster of accredited facilities in the state on
2 a monthly basis.

3 Now, we don't send them the deficiencies
4 that are found in each and every survey.
5 California, I think, is proposing that and
6 considering it, but they're also realizing that
7 that might come with a glut of information that
8 they don't necessarily want or need.

9 So, yes, we share, but it's not on a
10 regular basis because no one's required it yet.
11 But we don't as an organization see that as a
12 hurdle.

13 CHAIRMAN BEARISON: Dr. Winchester had his
14 hand up, and then we'll go to Dr. Rose.

15 DR. WINCHESTER: (Coughing.) Excuse me.

16 Again, looking at the office surgery rules,
17 it says the organization shall provide a copy of
18 the accreditation report to the Board. So, you
19 know, we're going to look back at these in
20 probably a few minutes, but that's the way the
21 rule is written for the office surgery is they
22 "shall".

23 CHAIRMAN BEARISON: Dr. Rose?

24 DR. ROSE: A question probably for counsel.
25 What do our laws and rules say regarding once we

1 receive this information? It's all going to be
2 in the public domain at some point, so the
3 consumer could go to a website and query
4 information about a particular facility and find
5 out what kind of inspection reports they've had,
6 what they've done, what deficiencies they've
7 had, whether they have been corrected, to allow
8 them to make an informed decision whether they
9 want to treat there or not.

10 MR. TELLECHEA: Well, I mean, any of the
11 material that's provided by one of these
12 entities to the Department of Health is going to
13 be a public record unless it contains any
14 material in it that is exempted from the public
15 record, such as, you know, patient
16 identification --

17 DR. ROSE: Or patient names.

18 MR. TELLECHEA: -- numbers and all that.

19 Now, whether it appears in a website or
20 not, I don't believe it appears in a website
21 right now. You know, that would be something
22 that -- it could be done if there were the
23 resources to do it. But it's my understanding
24 that that is not done right now.

25 Am I correct, Mr. McPherson? At least for

1 purposes for office surgery. Right.

2 I mean, all that's on there -- you can
3 ascertain whether they're accredited or not, but
4 it's not on a website for somebody to look up
5 right now.

6 DR. ROSE: How can a consumer find out
7 about a surgery center today, if they've ever
8 had any issues with their inspections with the
9 State or other problems that's public
10 information? How -- how do you inquire about
11 that to make a choice where you want to take
12 your three-year-old to have tonsils and ear
13 tubes put in?

14 MR. TELLECHEA: Well, you -- you would have
15 to know enough to make an inquiry with the
16 Department of Health is what it would have to --

17 MR. MCPHERSON: We would respond we have --
18 we keep a public record of every, you know,
19 adverse incident, and the other materials we
20 keep copies. So somebody would just have to ask
21 if somebody's registered and, if so, if they
22 want a copy of it, we would provide it to them.

23 CHAIRMAN BEARISON: Sir?

24 DR. ROSE: And this would be done in the
25 same way as far as we know for now then. Right?

1 MR. TELLECHEA: I suppose so. I mean, if
2 that's what you want.

3 Right now, I want to make a comment --

4 DR. ROSE: No. I'd rather it be on a
5 website or something where people could access
6 it and be more efficient if we could afford to
7 do that in the future.

8 MR. TELLECHEA: I want to make a comment --
9 I want to quick comment about the accreditation
10 reports that we get from the accrediting
11 agencies right now for office surgery.

12 Keep in mind that when people are
13 accredited by JACO or AAAASF, or these national
14 organizations, we don't get the survey reports
15 from those entities. We get accreditation
16 reports basically saying that they're
17 accredited.

18 The only ones we get the survey reports
19 from are from the other approved, the State
20 approved ones, which I think there's only one
21 right now, which is IMQ.

22 So we treat the nationally accredited
23 entities different under the office surgery than
24 we treat just the local statewide accrediting
25 agencies. There's kind of like two different

1 standards, but it's set up that way in statute
2 intentionally.

3 So that's something that you're going to
4 have to take a look at when you're making
5 considerations for these type of pain clinic
6 inspections.

7 CHAIRMAN BEARISON: Mr. Tellechea, why is
8 it set up intentionally that way?

9 MR. TELLECHEA: Well, the -- the statute
10 basically said -- by statute it says that any
11 nationally accredit -- nationally recognized
12 accrediting agency is approved.

13 So statutorily, they said, you know, JACO,
14 AAAASF, those entities were approved as a matter
15 of law. The Board of Medicine didn't have to
16 take applications from them, review them and
17 approve them as accrediting agencies. That was
18 already done by statute.

19 It only gave the Board the authority to --
20 to approve local, statewide accrediting agencies
21 and set the standards for those entities. So it
22 kind of had a bifurcated system. And we've only
23 had two of those that have been approved.

24 One of them was initially approved as a
25 matter of law and then when they reapplied two

1 more times they were denied. And then the third
2 one -- and the second entity, which has
3 currently been approved, IMQ, which I think has
4 been provisionally approved for one year, has
5 only been the second one. So that's the only
6 experience we've had with those two.

7 But the legislature intentionally set up a
8 different standard. We've tried to get that
9 statute changed to get rid of the statewide
10 approved entities because we didn't want to have
11 to deal with that anymore, but that hasn't
12 worked.

13 CHAIRMAN BEARISON: But what you're
14 speaking of is specifically for the surgical
15 centers, correct?

16 MR. TELLECHEA: Right. For the surgical
17 centers. It's not that way -- it's a different
18 --

19 CHAIRMAN BEARISON: That's my point.

20 MR. TELLECHEA: Right. Okay.

21 CHAIRMAN BEARISON: For this then, there's
22 not that bifurcation.

23 MR. TELLECHEA: That's correct.

24 CHAIRMAN BEARISON: So in other words the
25 nationally accredited agencies aren't

1 automatically approved by law.

2 MR. TELLECHEA: That's correct. Right.

3 CHAIRMAN BEARISON: Thank you for that
4 clarification.

5 Dr. Burns?

6 MR. TERRANOVA: I did -- I'm sorry. I was
7 just going to add I believe all of the
8 Medicare-approved agencies for any facility
9 that's participating in the Medicare program,
10 we're required to report to Medicare on a
11 quarterly basis all surveys done, and that does
12 include all of the deficiencies, all the
13 standards that were found to be out of
14 compliance.

15 Actually, that's only the Medicare
16 standards. So most of us have additional
17 standards that go outside of the Medicare
18 requirements or beyond the Medicare
19 requirements. But anything that's a Medicare
20 deficiency has to report to Medicare as well.

21 CHAIRMAN BEARISON: Thank you. Dr. Burns?

22 VICE-CHAIR BURNS: For the record, you
23 mentioned California and New York.

24 MR. TERRANOVA: Uh-huh.

25 VICE-CHAIR BURNS: Who else -- what other

1 entities recognize AAAASF for the record?

2 MR. TERRANOVA: Well, aside from -- we
3 actually just finished a long process of renewal
4 for our Medicare deeming authority.

5 And then several states -- Texas; Florida,
6 for office-based surgery, obviously; Washington,
7 for certain, you know -- ASFs is a way they
8 determine non-Medicare participating ASEs, and
9 also for office based; Colorado; Nevada. I
10 mean, I can't -- I think there's 27 of them.

11 VICE-CHAIR BURNS: Okay.

12 MR. TERRANOVA: Twenty-seven states.

13 VICE-CHAIR BURNS: And what basis do you
14 use for setting your survey standards?

15 MR. TERRANOVA: Well, right now they're
16 undergoing a little bit of a revision based on
17 some of the things that we've learned through
18 the Medicare renewal process, but those
19 standards committees are comprised of MDs and
20 DOs and they write the standards according to,
21 you know, several outside sources and practice
22 -- you know, practice standards.

23 Frankly the Standards Committee is a little
24 bit of a mystery to me because they operate kind
25 of outside of where I operate, but I do know

1 that they meet fairly regularly and review
2 standards on an ongoing basis.

3 VICE-CHAIR BURNS: And currently for the
4 office surgery rule, we have the requirement
5 that the organization meets using board
6 certified physicians or licensed risk managers
7 by the Agency.

8 Would you see any problem in meeting those
9 standards for this type of rule?

10 MR. TERRANOVA: Well, all of our
11 facilities, every physician in every facility
12 has to be board certified or board eligible
13 anyway, and all of our surveyors are board
14 certified or board eligible physicians.

15 The only time that you would have a -- as
16 it currently stands, the only time that there
17 would be a nonphysician on a survey team would
18 be when there are nurses on the survey team, but
19 they -- that team is also comprised of an MD or
20 a doctor of osteopathic medicine.

21 VICE-CHAIR BURNS: Uh-huh.

22 MR. TERRANOVA: So there's -- there's also
23 someone who is board certified on the -- on the
24 team.

25 VICE-CHAIR BURNS: Thank you.

1 CHAIRMAN BEARISON: Well, thank you very
2 much. And I understand you also came from afar.

3 MR. TERRANOVA: Chicago, as well.

4 CHAIRMAN BEARISON: Okay.

5 MR. TERRANOVA: We're all in Chicago.

6 CHAIRMAN BEARISON: I don't know if that's
7 dangerous or not.

8 (Laughter.)

9 But anyway, thank you very much for
10 providing us that information. We appreciate
11 your coming here today. Are you going to be
12 around if we have any other questions for --

13 MR. TERRANOVA: Yes.

14 CHAIRMAN BEARISON: Okay. Good. Thank
15 you.

16 MR. TERRANOVA: Yes.

17 CHAIRMAN BEARISON: Mr. McPherson?

18 MR. MCPHERSON: Yes, sir. The -- the last
19 card we have -- no, we have two more --
20 Dr. Gerber. Right. Gerber. Correct, Doctor?

21 DR. GERBER: Yes.

22 MR. MCPHERSON: Okay.

23 CHAIRMAN BEARISON: Please come forward and
24 be sworn in.

25 THE REPORTER: Do you swear or affirm that

1 the testimony you give here today will be the
2 truth, the whole truth and nothing but the
3 truth?

4 DR. GERBER: I do.

5 THE REPORTER: Thank you.

6 DR. GERBER: Thank you for letting me speak
7 for a second.

8 I just wanted to share a few points that I
9 had. I on the other hand did not travel very
10 far since I practice here in Orlando, but some
11 of you may know my name. I've been an expert
12 reviewer for the Board of Medicine and for AHCA
13 for the last eight years.

14 And I've personally emailed Ms. Sanford and
15 Mr. McPherson letting them know I'd be happy to
16 volunteer my time getting involved as we step on
17 new ground here trying to get these clinics
18 under control. And I have real-world knowledge.
19 I have a stack of charts that could fill an exam
20 room over the last few years of problems that we
21 have in this State.

22 I reviewed these charts and the real issue
23 of why we're here is quality of care, quality of
24 pain management care. How this is being
25 practiced by those clinicians. I'm concerned

1 about some of the accrediting organizations.

2 We've got excellent legislation here for
3 the Board to come in and review charts and
4 really see if doctors are doing a good job.
5 Don't let the cost fool you for accrediting.
6 These pain clinics and pill mills are making
7 millions of dollars a year.

8 You could charge them \$50,000 a year to get
9 accredited by an outside organization. They'll
10 spend it. Their charts would be perfect.
11 Policy and procedure manuals will be perfect.
12 They'll clean up their offices right before the
13 inspectors come in, and they'll pass their
14 inspections. But that doesn't mean anything
15 about how they practice pain management.

16 We need to make sure that these doctors are
17 doing it right. And the only way to do that is
18 to put some mandate in there that charts are
19 being reviewed. If you want to have a
20 accrediting organization, pull 20 or 30 charts
21 and have them be reviewed by board certified
22 pain specialists.

23 I'm fine with that. I don't care who the
24 accrediting organization is, but it needs to be
25 done right. We need to make sure that the

1 doctors are practicing pain medicine not just
2 passing inspections. And the boards got the
3 legislation to do that, but I'm concerned if we
4 give that up to some outside organization that
5 you guys have no control over, we don't really
6 know what's going on.

7 Because believe me, they will spend any
8 amount of money possible to just pass some
9 inspection, and that doesn't mean that they're
10 good pain docs. The two best things we have on
11 the legislation are having pain clinics being
12 owned by physicians and training them.

13 Everything -- I don't know if there's any
14 Board members that are pain specialists, but I
15 have some colleagues out here like Dr. Creamer.
16 We're very actively involved. I give CME talks
17 on substance abuse and diversion. I go around
18 the country. I lecture.

19 And the problems are not from board
20 certified pain specialists. And when I say
21 board certified, I'm talking about ACGME
22 accredited pain specialists. There's a lot of
23 organizations out there that will let you sit
24 for a test and all of a sudden you're board
25 certified. It means nothing because you can pay

1 money, take a test and become board certified.

2 There's tons of clinicians, chiropractors,
3 whatever who really claim that they're board --

4 CHAIRMAN BEARISON: Sir, I hate to
5 interrupt you, but we really want to focus on
6 the accrediting agencies so if you can kind of
7 limit your comments and kind of bring it back to
8 that, it'd be very helpful to us.

9 DR. GERBER: Okay. Last point. But that
10 was my point. I want to make sure that you guys
11 are aware of what happens when you relinquish
12 that authority and you're giving up that
13 inspecting capability of coming in unannounced
14 and looking at charts.

15 Please make sure that you have something in
16 this -- if you're going to approve outside
17 organizations, make sure that charts are being
18 reviewed and doctors are being looked at as are
19 they practicing pain management appropriately
20 not just whether they're passing some inspection
21 that ambulatory surgery centers go through,
22 hospitals go through because it's a different
23 ball game.

24 What you guys are trying to do the right
25 thing and I don't want to see -- I don't want to

1 have to review a chart next year for somebody
2 that got accredited by some outside organization
3 that's still doing things horribly just because
4 the charts perfect.

5 And I can tell you and you guys all know
6 this, every chart that I review from the pill
7 mills, they have an opioid agreement, they have
8 urine screens. And I can tell you how many
9 times the urine screens are aberrant. They're
10 positive for cocaine, marijuana, other things
11 that shouldn't be there. They just don't do
12 anything about it.

13 They're there. They go, oh, yeah, we do
14 urine screens. But they don't act on it and the
15 only way to know about that is to look at the
16 charts and have it reviewed by somebody who
17 knows what they're doing because just to have
18 the opioid agreement in there and the urine
19 screen means nothing. The charts can look
20 great. But that doesn't mean they're practicing
21 good medicine.

22 Thank you.

23 CHAIRMAN BEARISON: Dr. Winchester.

24 DR. WINCHESTER: Question for
25 Mr. Tellechea. If -- I'm looking at page 22 of

1 our proposed rule and it lists out requirements
2 for inspections. So if we approve an outside
3 organization, they have to abide by those rules;
4 is that correct?

5 MR. TELLECHEA: Well, they -- that's up to
6 you. I mean, I would put in the rule that, you
7 know, any entity that's approved has to make
8 sure that the -- that the facility being
9 inspected complies with the standards set for --
10 by the Department of Health and the Board of
11 Medicine and their statutes and rules for pain
12 clinic. That's one of the requirements.

13 DR. WINCHESTER: Right. And one of the
14 requirements in those inspection accreditation
15 rules is a random selection of patient records.

16 MR. TELLECHEA: Well, that's what the
17 Department's going to do when they're inspecting
18 it.

19 DR. WINCHESTER: That's the question I'm
20 asking.

21 MR. TELLECHEA: No, you would have to put
22 in the rule if you want them to go in there when
23 they're doing the surveys to inspect medical
24 records on whatever basis it is, an annual
25 basis. Whatever the case may be. You're going

1 to have to put in your rule that in order for
2 these entities to be approved they have to agree
3 to do that.

4 DR. WINCHESTER: Okay. So for example, if
5 we took this set of requirements for inspection
6 as the State says, and put in our rule for
7 outside organizations they have to meet these
8 same requirements?

9 MR. TELLECHEA: That's correct.

10 DR. WINCHESTER: Okay.

11 MR. TELLECHEA: That's what you would have
12 to do, yes.

13 CHAIRMAN BEARISON: I think that's an
14 excellent point, and that should solve the
15 problem that you brought up, sir.

16 DR. GERBER: If that's done legally by
17 those accrediting organizations. They have
18 their own policies and procedures. They may
19 say, well, that's not what our organization
20 does.

21 CHAIRMAN BEARISON: Then it won't be
22 approved.

23 MR. TELLECHEA: Then they won't get
24 approved.

25 DR. GERBER: Okay.

1 CHAIRMAN BEARISON: They have to follow our
2 rules. And Mr. Tellechea, from a legal point of
3 view, we would just have to put that in our
4 rules?

5 MR. TELLECHEA: That's correct. You would
6 say -- you'd have put in your rules and say if
7 you're going to survey and accredit these
8 entities in order for your accreditation to be
9 recognized by the Board of Medicine, Department
10 of Health, you have to do your accreditation and
11 surveys according to our standards.

12 At a minimum meet our standards. If you
13 have standards that go over and above the Board
14 of medicine, that's fine. Hunky-dory. That's
15 up to you folks to make sure they comply with
16 us, but at a minimum they have to meet Board of
17 Medicine standards for -- and Department of
18 Health standards for accreditation and
19 inspections.

20 CHAIRMAN BEARISON: Very well. Excellent
21 point. Thank you very much, sir.

22 MR. MCPHERSON: Mr. Chair, the last speaker
23 on accreditation is Debbi Conn from Florida
24 Healthcare -- Universal Healthcare.

25 CHAIRMAN BEARISON: I'm sorry. Where --

1 you can tell us where you're from and who you
2 represent.

3 MS. CONN: I'm a licensed risk manager here
4 in Florida. I do inspections for the Department
5 of Health for office surgery --

6 MR. MCPHERSON: Could you --

7 CHAIRMAN BEARISON: Can you be sworn in,
8 please?

9 THE REPORTER: Do you swear or affirm that
10 the testimony you give here today will be the
11 truth, the whole truth and nothing but the
12 truth?

13 MS. CONN: Yes.

14 THE REPORTER: Thank you.

15 CHAIRMAN BEARISON: Go ahead, ma'am.

16 MS. CONN: I just wanted for a little
17 clarification. I know Dr. Winchester was
18 referring a lot to the office surgery rule, and
19 as a state inspector doing the on-site
20 inspections and working with the accrediting
21 agencies that are approved currently for office
22 surgery, to address some of those issues to help
23 clarify things for you.

24 Currently the accrediting bodies do not
25 inspect according to the Florida rule. They

1 inspect according to their own standards for
2 office surgeries. They're not incorporating the
3 State rule. What Mr. Tellechea just spoke with
4 on the last speaker on having the -- do that for
5 pain, would be extremely helpful in covering
6 everything.

7 What we do as risk managers when we have
8 our own clients is we ensure that the facilities
9 meet the highest standard of all, both the
10 accrediting body and the State of Florida. But
11 we do see that.

12 As far as the reporting, AHCA requires the
13 full report from the accrediting agencies sent
14 to them. They are sent by the facility. The
15 Board of Medicine is currently only requiring
16 the letter to say that the facility is
17 accredited. They're not seeing the entire
18 report.

19 MR. TELLECHEA: Are we talking about the
20 nationally recognized accrediting agencies,
21 right?

22 MS. CONN: Yes.

23 MR. TELLECHEA: Yeah, I -- and again,
24 that's why I was talking about why it's
25 bifurcated. Because the legislature has just as

1 a matter of statute they've approved JACO,
2 AAAASF and these entities. They nationally
3 recognize accrediting agencies.

4 So if you get accredited by those entities
5 regardless of what standard they use for
6 accreditation, you're good to go for the purpose
7 of office surgery and all they have to do is
8 cough up documentation saying, I'm accredited by
9 these people. I'm good to go. Stay away from
10 me. Don't inspect me.

11 MS. CONN: Correct.

12 MR. TELLECHEA: With the Department of
13 Health. Now, this is different though. The way
14 you have it set up because we -- they're not
15 approved as a matter of law. They give the
16 Board of Medicine the authority and the Board of
17 Osteopathic Medicine the authority to approve
18 national accrediting agencies.

19 So this is a different ball game. It gives
20 you a whole new level of oversight of these
21 national entities. So that's why -- basically
22 we're going to be treating these entities just
23 like we treat now the just the state recognized
24 accrediting agencies that the Board of Medicine
25 has.

1 That's why these rules that were handed out
2 by Mr. McPherson and the Board staff for the
3 Board of Medicine office surgery accrediting
4 entities. That's why he's handing you out
5 because this is basically what we're going to be
6 doing, but we're going to be doing it for all
7 the facilities. The nationally recognized and
8 the -- well, it's only nationally recognized in
9 this case, so --

10 MS. CONN: And above and beyond your
11 requiring the quarterly reporting and then the
12 annual report.

13 MR. TELLECHEA: Right. Uh-huh.

14 MS. CONN: Which is not required for office
15 surgery, but will keep you to be able to cover
16 all of the pain management facilities whether
17 they're accredited or state inspected.

18 CHAIRMAN BEARISON: Dr. Burns.

19 VICE-CHAIR BURNS: Just a point of
20 clarification as we're discussing the standards
21 for our approval of physician office accrediting
22 organizations if you look in the middle of the
23 first page "Standards," it says, "the standards
24 adopted by an accrediting organization," and it
25 goes on to say, "shall meet or exceed provisions

1 of Chapters 456, 458, and rules promulgated
2 there under."

3 MR. TELLECHEA: Right. But that's not for
4 the nationally recognized accrediting agencies.
5 That's just for the ones that the Board of
6 Medicine, the Board of Osteopathic Medicines
7 have the authority to approve.

8 Remember, they split it up two ways. The
9 nationally recognized -- this is for office
10 surgery now -- the nationally recognized
11 accrediting agencies are approved as a matter of
12 law. We don't have any authority over what
13 their standards are or anything.

14 These rules are just for the local
15 accrediting agencies like FLAX (ph) was
16 originally and now IMQA -- IMQ is, correct?
17 Just for those entities. This has nothing to do
18 with AAAASF, JACO and those entities.

19 VICE-CHAIR BURNS: So we'd be careful in
20 this new rule that we're considering that we'd
21 want to make it very clear and specify that we
22 have that control over the national
23 organization.

24 MS. CONN: Yes. That's what we're
25 encouraging.

1 MR. TELLECHEA: Well, that's in control.
2 But you set the standards. If they want to
3 comply with those standards, fine. They're
4 approved. If they don't want to comply with
5 those standards, then they're not going to be
6 considered approved. That's it.

7 CHAIRMAN BEARISON: Other Committee
8 members?

9 Ma'am did you have anything else?

10 MS. CONN: Nope. Thank you.

11 CHAIRMAN BEARISON: Thank you very much.
12 That was very informative also.

13 MR. MCPHERSON: Mr. Chair, that concludes
14 the speakers on the accreditation issue. So
15 Mr. Chair, you may want to have a 15 minute
16 break. You may want to start looking at the
17 template and start going through that and
18 working on that.

19 CHAIRMAN BEARISON: Why don't we go ahead
20 and take a 15-minute break now. That'll give
21 Committee members time to check out and we'll
22 come back about 10:00 then we can tackle that.

23 Thank you, everybody.

24 (A break was had.)

25 CHAIRMAN BEARISON: Mr. McPherson, from an

1 administrative point of view, what would be your
2 recommendation that we go ahead and do next
3 before moving on to the second portion
4 discussing the prescriptions?

5 MR. MCPHERSON: Well, Mr. Chair, you've
6 heard the public comment, you've seen the
7 written materials, and I think it would be
8 helpful if the members would look at the
9 template we handed out today, the template for
10 the accreditation of physician offices, the
11 accreditation rule for that, and I think from
12 that decide what is going to be applicable here
13 and delete which will not be applicable or
14 substitute phrases or words.

15 I think this would be a good starting point
16 to use this.

17 CHAIRMAN BEARISON: Very well. I think
18 that's the next recommendation. Let's get
19 started with that. And everybody knows what
20 we're speaking of. It's --

21 VICE-CHAIR BURNS: Yes.

22 CHAIRMAN BEARISON: Good. Okay. It's the
23 64B8-9.009(2), Approval of Physician Office
24 Accrediting Organizations.

25 And I believe that's been provided to the

1 public, Mr. McPherson?

2 MR. MCPHERSON: Yes, sir.

3 CHAIRMAN BEARISON: Okay. So for everybody
4 out in the audience that's -- that's what we're
5 speaking about.

6 Dr. Winchester, would you like to get
7 started?

8 DR. WINCHESTER: Yeah. I was going to
9 request that Ed or Larry, one, walk us through
10 changing all the surgery rules to insert the
11 ones from the -- from the proposed rule on pain
12 management.

13 CHAIRMAN BEARISON: I think that's an
14 excellent idea. I don't think we need to
15 reinvent the wheel here. So --

16 MR. TELLECHEA: We'll --

17 CHAIRMAN BEARISON: Mr. Tellechea?

18 MR. TELLECHEA: You know, if you tell me
19 basically what you want in the rule. You know,
20 what are the parameters? What are exactly the
21 things that you're going to look at?

22 I think -- instead of going through this
23 rule saying "we want this, we don't want this,"
24 give us the basic parameters of it. Donna,
25 Nancy and I will sit down. We'll -- we'll use

1 the parameters you've given to amend -- to
2 change the language in that rule and then we'll
3 bring something back to you in that regard, if
4 you would rather do it that way. I think that
5 would be more efficient.

6 And then once you get the draft in front of
7 you, then you can fine-tune it and make whatever
8 changes you want to it at that point in time.

9 DR. ROSENBERG: There's clearly some stuff
10 in there that's specific for surgery, you know,
11 post-operative stuff, obviously that needs to be
12 dropped. And I'm not sure what we need to add
13 that is more specific for pain management, but I
14 agree, using this as a template would be great.

15 CHAIRMAN BEARISON: Dr. Burns?

16 VICE-CHAIR BURNS: Specific requirement, I
17 think, for pain management would be that this
18 would be in accordance with the Board of
19 Medicine and Board of Osteopathic Medicine
20 inspection standards.

21 CHAIRMAN BEARISON: Ms. McNulty, did you
22 have your hand up?

23 MS. MCNULTY: No.

24 CHAIRMAN BEARISON: Dr. Tucker and then
25 Dr. Winchester.

1 DR. TUCKER: There's a provision in here
2 that I think just needs some tweaking, but I do
3 like it. That the surveyor must be an ABMS or I
4 guess AAPS since we've recognized that as well,
5 board certified physician with two years of
6 experience with pain management.

7 MR. TELLECHEA: Yes. And then with the DOs
8 it would be AOA, right.

9 CHAIRMAN BEARISON: Which number is that,
10 for the audience's benefit?

11 DR. TUCKER: That's number one --
12 subsection D, number -- let's see, number 1.

13 CHAIRMAN BEARISON: So we're --

14 UNIDENTIFIED SPEAKER: About half way down
15 the page (not using microphone).

16 DR. TUCKER: Yeah. The surveyor must be
17 ABMS or AAPS or AOA.

18 CHAIRMAN BEARISON: So in other words, just
19 number 3 there?

20 DR. TUCKER: Actually, it's number 1.
21 Number 3 states about administering anesthesia.
22 But I think if we say with experience in pain
23 management, that should be sufficient.

24 And I like the disciplinary, no
25 disciplinary action as well.

1 CHAIRMAN BEARISON: Uh-huh. So that would
2 be in number 4 then.

3 DR. TUCKER: Yes. And of course, they must
4 comply with the rules sent out by the Board,
5 statute. Okay.

6 MR. TELLECHEA: Well, the way that this
7 rule reads, it says that "the surveyor must be
8 an AMBS or," for osteo version, "an AOA
9 certified physician." But then "...with two
10 years' experience performing office surgery."
11 But then it says "or Florida Health Care risk
12 manager, licensed through AHCA with two years
13 experience serving as a risk manager in a
14 surgical facility."

15 Do you want to retain that or do you want
16 to get rid of that? How would you prefer? And
17 I think, Gary, since you're a risk management
18 you may want to provide some input on that.
19 Excuse me, Dr. Winchester.

20 DR. WINCHESTER: You know, quite frankly, I
21 would leave 2 and 3 out and just stick with 1.

22 MR. TELLECHEA: Yeah. Well, 3 definitely
23 needs to go.

24 DR. WINCHESTER: Yeah, right.

25 MR. TELLECHEA: Okay. All right.

1 DR. WINCHESTER: Because I'm not sure, you
2 know, right now at least, that you're going to
3 find risk managers that have two years of
4 experience in --

5 DR. TUCKER: Pain medicine.

6 DR. WINCHESTER: -- in pain medicine.

7 MR. TELLECHEA: Is that a motion? Were you
8 just going to give us some general guidance?

9 DR. TUCKER: Yeah.

10 MR. TELLECHEA: Okay.

11 DR. TUCKER: That's what I was hoping.

12 CHAIRMAN BEARISON: Do you think we should
13 give you just general guidance and then come
14 back and ask us to approve it? Or what would
15 work best for you from a legal point of view and
16 administratively to get this thing done?

17 Either one of you or both of you?

18 MS. MCNULTY: I think at this point, I
19 think it would be helpful just to get
20 preliminary ideas so we can draft something and
21 then kind of get input from you, bring something
22 back to the next meeting, and then you can firm
23 it up more then.

24 MR. TELLECHEA: Yeah. I think this is more
25 like input, discussion amongst you folks, and

1 then when you reach a consensus let us know what
2 you want and then we'll draft it and bring it
3 back to you. And when you have the language
4 then we'll approve the language.

5 CHAIRMAN BEARISON: Okay. One question I
6 have to the members.

7 If there are people in the audience that
8 want to comment about what we're speaking about,
9 do you wish to hear that comment? Do you want
10 me to recognize them or are we closed on public
11 comments?

12 DR. TUCKER: Huh-uh.

13 CHAIRMAN BEARISON: What does the Committee
14 members want to do about that?

15 DR. TUCKER: Closed.

16 DR. ROSE: Closed.

17 CHAIRMAN BEARISON: Very well. Okay.

18 So as far as -- I think we should just take
19 each thing at a time. So as far as that,
20 Mr. Tellechea, you have an idea -- and
21 Ms. McNulty and Ms. Murphy, who is probably
22 going to do most of the work --

23 (Laughter.)

24 -- you have an idea of what we want to do
25 regarding that?

1 MR. TELLECHEA: Well, some of it so far.

2 CHAIRMAN BEARISON: Well, just that one
3 issue.

4 MR. TELLECHEA: Yeah. Yeah. I understand
5 all the stuff in here about anesthesiologists.
6 We're going to get rid of that.

7 DR. TUCKER: Uh-huh.

8 MR. TELLECHEA: Because this is a different
9 -- it's not -- so I understand that. I
10 understand the surveyor language. And you want
11 language in there saying that they have to
12 comply with -- at a minimum they have to comply
13 with Florida standards.

14 DR. TUCKER: Uh-huh.

15 MR. TELLECHEA: Do you want some language
16 in there about them providing copies of their
17 survey reports --

18 DR. TUCKER: Yes.

19 MR. TELLECHEA: -- survey reports and
20 accreditation reports?

21 DR. TUCKER: Yes.

22 MR. TELLECHEA: That they have to agree --
23 they have to agree that the entity being
24 accredited by these organizations must sign a
25 waiver allowing the accrediting agency to

1 provide us with survey reports and accrediting
2 reports.

3 DR. ROSE: Yes.

4 MR. TELLECHEA: Is that --

5 DR. TUCKER: Yes.

6 MR. TELLECHEA: Okay.

7 CHAIRMAN BEARISON: Ms. Goersch and then
8 Dr. Winchester.

9 MS. GOERSCH: Yeah. And then we had also
10 talked about that the surveys themselves need to
11 mirror our inspections. That that is very
12 specific in there as well, that it is -- because
13 not that, whatever their accreditation
14 standards, but it is our inspection standards,
15 so that, as a minimum, the same or at least has
16 to cover --

17 MR. TELLECHEA: Can you -- I can't -- I can
18 barely hear you. Can you move the microphone a
19 little closer.

20 DR. TUCKER: You don't want her to yell at
21 you.

22 MR. TELLECHEA: I'm used to that. Don't
23 worry about it.

24 (Laughter.)

25 MS. GOERSCH: The survey -- the surveys

1 themselves that the surveys --

2 MR. TELLECHEA: Uh-huh.

3 MS. GOERSCH: -- that the surveys have, as
4 a minimum, the same as our inspection standards.

5 MR. TELLECHEA: Okay.

6 MS. GOERSCH: Because remember, we had some
7 discussion about that we did not want to have
8 the accrediting body's survey standards, which
9 maybe differ and could be less. We wanted to
10 have ours as a minimum included in that.

11 MR. TELLECHEA: Okay.

12 CHAIRMAN BEARISON: Dr. Winchester, did you
13 have your hand up?

14 DR. WINCHESTER: Yeah. As far as reporting
15 is concerned, I would suggest that they shall
16 provide a copy of the accreditation report and
17 the release has to allow the Department to get a
18 copy of the survey.

19 The reason I think we need to have the
20 accreditation report on file is that if -- if
21 somebody in the public calls up and says "Clinic
22 X, are they accredited," then the State would be
23 able to, you know, say that they are accredited.

24 MS. MCNULTY: May I ask a follow-up
25 question to Dr. Winchester?

1 CHAIRMAN BEARISON: Uh-huh.

2 MS. MCNULTY: What about also for the
3 survey report? Do you think that's necessary or
4 unnecessary? I'm just trying to --

5 DR. WINCHESTER: What I'd like to have is
6 the accreditation report filed with the State.

7 MS. MCNULTY: Right.

8 DR. WINCHESTER: And have the release form
9 allow the State to look at the survey report.

10 MS. GOERSCH: I think they should send it.
11 We had heard -- we heard testimony today that
12 some states require that they be sent. And I --
13 I think they should be sent -- I personally
14 liked Dr. Rose's idea earlier where -- for
15 consumer -- from a consumer's perspective, if we
16 get the accreditation report sent to us, it's on
17 file. That that somehow is on the website --
18 that we post that somehow that this is an
19 accredited facility.

20 And it doesn't have to have the whole
21 report, just to say -- so we have some basis of
22 somehow posting that it's accredited. And then
23 -- and then have the surveys on file if somebody
24 really wants more detailed information. But
25 allows if there's a concern that comes up and

1 allows a place to go immediately, without having
2 to go say "send me a copy", you know, you're
3 losing days. You're losing time that way.

4 CHAIRMAN BEARISON: Dr. Winchester? And
5 then we'll go to that side.

6 DR. WINCHESTER: The only reason I would
7 speak against that is that we're putting a lot
8 of burden back on the Department. And I guess
9 maybe the Department would like to respond, but
10 if the accreditation report is on file then I
11 think the consumer should be able to assume that
12 all the requirements in the rule have been met.
13 And I don't know that putting the added burden
14 of actually putting online every survey is
15 necessary.

16 MS. GOERSCH: Only if it's accredited. You
17 know, a place to look to see if it's accredited.

18 DR. WINCHESTER: Okay. I thought you said
19 you wanted to have the survey reports.

20 DR. TUCKER: Not online.

21 MS. GOERSCH: Not online. The survey
22 reports are -- that they're sent just like they
23 are in other states, that they are -- in other
24 states, that they're at the Department. But not
25 that those are posted. In fact, not even the

1 accreditation report. Only that there's a place
2 to go where a consumer can see this is an
3 accredited clinic.

4 CHAIRMAN BEARISON: Dr. Rose? Did you want
5 to make a comment first, though, Mr. Tellechea.

6 MR. TELLECHEA: I'm listening right now.

7 CHAIRMAN BEARISON: Okay. Good.

8 Dr. Rose?

9 DR. ROSE: I think it's important that the
10 State house copies of those survey reports in
11 case questions come up because there was an
12 instance of an outpatient surgery center
13 recently that a relative of mine had some
14 concerns about, and we were able to find,
15 through some help from the office to locate the
16 right place where you can go to see what issues
17 that they've had in the past, and that they were
18 corrected.

19 So, however, the Department wants to house
20 that or make that available to the consumer,
21 they should be there. So if you want to go to a
22 pain management clinic and you want to know how
23 they did on their surveys, what their
24 deficiencies were, how long it took until they
25 corrected it, you can do that, because I think

1 that's useful to the consumer in making their
2 decision.

3 The new point that I wanted to make was
4 based on the testimony we heard is that the
5 component wherein an inspector or someone looks
6 at the actual chart review, I realize there may
7 be many different disciplines involved in
8 inspecting the facilities, from engineers
9 looking at the structural plan to risk managers
10 and certified nurses handling different parts of
11 the patient care component. But I think the
12 chart review should be restricted to someone
13 that is board certified in pain medicine, and we
14 can define which boards they need to be to be
15 eligible to do that so that any entity we
16 contract to at least that one component of it,
17 at a minimal has to be done by a board certified
18 pain management physician who would be able to
19 really look at that chart and understand what's
20 going on and read between the lines, so someone
21 couldn't just buff a chart up and make it look
22 good for a surveyor, when someone is actually
23 practicing pain medicine and they could see all
24 the pitfalls and what they're trying to cover up
25 or not covering up, and maybe it's just fine.

1 But they would have the ability to do the
2 follow-thru and say "this looks good, but now
3 let me see the whatever supporting document for
4 this," or "you had an abnormal screen here, show
5 me the follow up, where is it, is that there,"
6 and all that kind of stuff.

7 I think it's really crucial that for
8 patient quality and safety that that one
9 component be done by a board certified
10 physician, because I don't think any nurse, any
11 PhD or any other discipline can do that to that
12 extent. It's a pure peer review.

13 DR. WINCHESTER: Agreed. That's good.

14 DR. ROSENBERG: I'd like to strongly
15 endorse Dr. Rose's recommendation that that be
16 embraced.

17 DR. ROSE: Thank you.

18 CHAIRMAN BEARISON: Mr. Tellechea?

19 MR. TELLECHEA: We -- we can go ahead and
20 do that and put that in the rule. But on the
21 issue of the survey report, you know, I want to
22 emphasize that at a minimum you need to have --
23 we need to have access to those survey reports.
24 Because in -- when we were involved in that FLAX
25 litigation, those two different cases that we

1 had to do them. I mean, those cases -- those
2 cases were won on what appeared on the data that
3 came out of those survey reports. Because the
4 survey reports indicated that these people were
5 being accredited prior to meeting all the
6 requirements.

7 So I think it's key that in order to
8 monitor these entities that we have at least
9 access to those survey reports. Now, whether
10 you want them, you know, as a matter of fact to
11 file them with the Board of Medicine all the
12 time, that's a different story, but at least we
13 have to have access to them.

14 So if we contact them saying "you need to
15 cough them up," they need to cough then up.

16 CHAIRMAN BEARISON: Mr. McPherson and then
17 Dr. Tucker?

18 MR. MCPHERSON: On the -- I think it's a
19 great idea for us to have on the website whether
20 or not an entity is accredited. And if somebody
21 wants to get a report of the survey, then they
22 should go to the entity that created the survey.

23 I think if you are requiring the Board of
24 Medicine, the Board of Osteopathic Medicine to
25 be a repository of every survey and respond to

1 public requests for all those, then that -- that
2 would be something of a workload.

3 I would ask you to consider --

4 DR. ROSE: The only problem with that is
5 the entity won't do that. They will say "well
6 this is confidential information, you'd have to
7 go to the facility to get it."

8 You know, the Joint Commission is not going
9 to release you a copy of what the hospital
10 survey was. As chief of stuff, they even
11 blocked me from seeing certain things that the
12 hospital had.

13 So for the consumer to get it, there would
14 be no way. But if -- if it was a requirement
15 that that information be provided to the State,
16 and it could be upon request, it could be
17 handled that way.

18 Or, you know, I don't know if there's any
19 way that the facility themselves, the registered
20 pain management clinic, would likely voluntarily
21 give that to a consumer either.

22 MR. MCPHERSON: I will tell you that if you
23 could picture -- let's say we have a thousand
24 clinics, if you can picture maybe 300 having --
25 or more having this inspection. And if you can

1 picture how many requests we would get -- phone,
2 fax, emails.

3 DR. ROSE: Require them to submit it to you
4 in any electronic format, in PDFs something, so
5 it's easily stored.

6 MR. MCPHERSON: And then we would -- and
7 you know, in this -- in this environment, this
8 economy, we're not going to be able to get
9 additional people or additional resources.

10 So this, I think, would be a major workload
11 issue. And we don't want to drop the ball
12 somewhere else to -- to take on the new task.
13 So I would ask you to please consider an
14 alternative to your Board offices maintaining
15 copies of survey -- surveys subject to a public
16 records request.

17 CHAIRMAN BEARISON: Let's some of our
18 Committee discussion now specifically, I guess,
19 to that issue so that we can kind of get
20 everybody's opinion on that before we go on to
21 something else.

22 Dr. Tucker?

23 DR. TUCKER: I just had a thought. You
24 know, you go in a restaurant and they've got
25 their health department inspection and their

1 grade posted somewhere in the restaurant.

2 I wonder if we could mandate the clinics
3 have their most recent survey posted in the
4 clinic so that if a patient is interested in
5 going in that clinic, they can just go there.
6 They can see it, they don't have to get it from
7 the Department of Health, and they can go see.
8 And the inspector comes in and sees that their
9 last accrediting survey is up to date.

10 I wonder if we could do that. Because then
11 that would limit the paper load on the
12 Department, but would allow the patients and the
13 public access to those reports.

14 CHAIRMAN BEARISON: I want to go down the
15 line.

16 Ms. Goersch?

17 MS. GOERSCH: Yeah. I like that idea. I
18 will tell you that most people though do a lot
19 of research online. They try to research before
20 they actually go to a clinic and go, say, walk
21 in the door and say "hey, I want to see your
22 survey."

23 I'm just looking at what -- maybe we could
24 find something in between that works. I do like
25 the -- who had the idea about electronic? I

1 like that a lot. Just require electronic
2 submissions. We dictate the format.

3 Maybe we even have an FTP site where you
4 have to just deposit to, so the Department
5 doesn't even have to deal with it. It's just
6 there. It's secure access. You can deposit to
7 it. Only the Department accesses if they need
8 it. So it's -- it's already done. It's already
9 stored for you. It's already there.

10 I mean, there's ways to do this
11 electronically where you don't have the burden.
12 I appreciate the burden. We don't want to
13 create more burden. But you're going to have
14 public records requests. I mean, it's just --
15 it's life.

16 CHAIRMAN BEARISON: Dr. Winchester?

17 DR. WINCHESTER: I like Dr. Tucker's idea,
18 except I would change the word "posted" to
19 something like "available" because I don't think
20 it is appropriate to have 25 pages, you know,
21 stuck on the wall.

22 DR. TUCKER: Oh, I didn't know it would be
23 that many. But, yeah, "available". Yeah, I
24 think that -- I didn't realize it would be that
25 many pages posted there. I thought there would

1 just be a summary page that they could post.
2 But somewhere available in the office setting.

3 CHAIRMAN BEARISON: Dr. Rosenberg? Then
4 we're going to go to Dr. Burns?

5 DR. ROSENBERG: Yes. I'd go along with
6 Dr. Winchester's recommendation. But I'm also
7 curious how many patients are even likely or
8 interested in requested that information when
9 they're going to a facility where they're main
10 interest is getting rid of their pain.

11 I have a feeling we're not looking at a
12 very significant of people that are going to be
13 requesting this information.

14 CHAIRMAN BEARISON: Dr. Burns?

15 VICE-CHAIR BURNS: I think one issue to
16 resolve here is if we could ask the Department
17 if they feel that it would not be too cumbersome
18 to have entities required to submit a PDF file
19 that the consumer could click on and simply look
20 on their own computer screen or download at home
21 the survey that was performed.

22 If you have it required to be submitted in
23 a PDF file, that would be less of a burden and
24 workforce issue.

25 MS. GOERSCH: That's true. Yeah. The

1 consumer just looks; you don't even have to deal
2 with it.

3 VICE-CHAIR BURNS: And just have it on the
4 website so that the consumer could click on that
5 if they wish and review it.

6 UNIDENTIFIED SPEAKER: Who's website?

7 VICE-CHAIR BURNS: This would be the
8 Department's website.

9 DR. ROSENBERG: You could make the
10 accrediting entities maintain that on their
11 website and have it linked to our website, and
12 so that the facilities they're surveying in
13 Florida, they have to put that on there and
14 maintain it so we could have a link to it. We
15 could set it up that way.

16 CHAIRMAN BEARISON: Ms. Sanford?

17 MS. SANFORD: We do have a computer policy
18 that would prevent us to link to another, so.

19 CHAIRMAN BEARISON: Outside agency.

20 DR. ROSENBERG: Well, then we could have
21 the information where to go to and refer to that
22 site if they're accredited by this body, to go
23 to that site, and make them maintain it for the
24 Florida-inspected facilities.

25 CHAIRMAN BEARISON: Mr. McPherson?

1 MR. MCPHERSON: Would you allow the -- the
2 draft of this when it comes back to you to
3 provide an option that would not have the
4 Department be the repository and provide an
5 option for either the -- either the entity that
6 has the survey to make it available to people
7 who request it?

8 DR. ROSENBERG: Yeah, absolutely.

9 CHAIRMAN BEARISON: I think that's kind of
10 the feeling of the Committee is that we want
11 that information available at a fairly easy way
12 to the public, and how's that accomplished is, I
13 think, the question. But I think there's a
14 couple ideas which maybe when you go ahead and
15 give us some wordage back, maybe you can provide
16 us two or three options which are reasonable.

17 Does that sound like something,
18 Mr. Tellechea, you and Ms. McNulty and
19 Ms. Murphy can do for us?

20 MR. TELLECHEA: If that's what you want,
21 we'll do it.

22 CHAIRMAN BEARISON: And then we can see the
23 actual options in words and kind of figure out
24 what would be the best way.

25 DR. TUCKER: And I suppose what I'm about

1 to say may fall into the standards of
2 inspections, but if a survey has deficiencies,
3 if it finds deficiencies, I think we want to
4 know that it had deficiencies and we want to
5 know that those deficiencies have been
6 corrected.

7 And I presume that that's very similar to
8 what an inspection report would be. Okay.

9 MR. TELLECHEA: Yeah. And I think somebody
10 had already said that most of the times they do
11 the surveys. They -- the vast majority of the
12 time they find -- they find deficiencies. It's
13 just a matter of whether the deficiencies are
14 inspected.

15 And I'm assuming that when the Department
16 of Health does inspections for office surgery
17 facilities they usually find deficiencies; am I
18 correct? And then they correct them. So --
19 okay.

20 CHAIRMAN BEARISON: One thing that I
21 thought of, and I guess it may fall in here, and
22 I'll ask Mr. Tellechea, since we're going to
23 require that these accrediting agencies follow
24 our rules, and my understanding is when the
25 Department of Health goes in, and our rules

1 aren't followed, then a complaint may be filed
2 with the Department of Health if a physician is
3 not doing what he is supposed to do, correct?

4 MR. TELLECHEA: Well -- well, when the
5 Department of Health is doing it, I mean, they
6 find deficiencies usually most of the time and
7 they correct them.

8 I suppose that there could be a situation
9 where they just never correct them, they keep on
10 having problems, and then they eventually get
11 referred to the Department for prosecution.

12 I think with the private entities --

13 CHAIRMAN BEARISON: Well, that was
14 question.

15 MR. TELLECHEA: -- with the private
16 entities, if they find -- if they find -- if
17 they survey the place, they don't meet the
18 requirements, then they do a follow up and they
19 continue to not meet the requirements, they just
20 don't get accredited. And then they have to go
21 through the Department of Health and then the
22 Department of Health of will do the inspection.

23 CHAIRMAN BEARISON: So, do you -- and maybe
24 the other Committee members -- do you feel that
25 we should have something in our rules that

1 requires these agencies to make a referral to
2 the Department of Health if they find that, for
3 example, the physicians in a pain clinic aren't
4 following our rules?

5 Because if the Department of Health
6 inspects it and finds that, then eventually
7 they're not corrected, they're going to file a
8 --

9 VICE-CHAIR BURNS: Complaint.

10 CHAIRMAN BEARISON: -- complaint with the
11 Department of Health.

12 So do we want to require these other
13 agencies to also do that? Or as Mr. Tellechea
14 said, just that they won't be accredited and
15 they're going to have to end up going to the
16 Department of Health anyway.

17 VICE-CHAIR BURNS: Well --

18 CHAIRMAN BEARISON: Can you comment on
19 this, Mr. Tellechea, and then the Committee
20 members?

21 MR. TELLECHEA: Yeah. You know, I don't
22 know if you want to get the -- I don't -- you
23 know, if I was representing one of these
24 entities and there was a requirement in there
25 that said you have to turn them into the

1 Department of Health if they don't meet, I'm
2 going to say "we're not to get in the business
3 of that" because then, you know, there's
4 liability, lawsuits, all kinds of stuff like
5 that.

6 I don't know if you want to get -- make
7 these requirements so onerous that none of these
8 entities are going to want to get involved in
9 doing this at all, you know.

10 So, you know, it's your call if that's what
11 you want to do. But, again, if I representing
12 JACO and that was a requirement, I'd say "we're
13 not going to do it then because I don't want to
14 get sued."

15 CHAIRMAN BEARISON: I think if they're not
16 going to accredit them, that's sufficient
17 information for us and then we can -- you know,
18 they'll have to find another method.

19 MR. TELLECHEA: They'll have to go to the
20 Department of Health --

21 CHAIRMAN BEARISON: Yeah, exactly.

22 MR. TELLECHEA: -- or find another entity
23 that's going to go ahead and try to correct it.

24 CHAIRMAN BEARISON: Or fix their problem.

25 MR. TELLECHEA: Right.

1 CHAIRMAN BEARISON: Dr. Burns?

2 VICE-CHAIR BURNS: On the last page of our
3 office surgery rules you'll see that there's a
4 provision that says "an accrediting agency or
5 organization finds indications during the
6 accreditation activities that the condition of a
7 physician's office pose a potential threat to
8 patients, the accrediting agency or organization
9 will immediately report the situation to the
10 Department."

11 DR. TUCKER: Uh-huh.

12 VICE-CHAIR BURNS: So having provisions
13 similar to this --

14 DR. TUCKER: Yeah.

15 VICE-CHAIR BURNS: -- I think would be
16 protective to the citizens.

17 DR. TUCKER: Yeah. That sounds good.

18 CHAIRMAN BEARISON: I think that's the
19 answer to the question if we want to continue
20 with what they do in the office surgery rules
21 that this would be in there, which in essence
22 then means that these accrediting agencies, as
23 they would do with the office surgery rules,
24 would be obligated to report a potentially
25 dangerous situation to the --

1 DR. ROSENBERG: But this office surgery
2 rule didn't apply to the national accrediting
3 agencies, right?

4 MR. TELLECHEA: That's correct. Keep in
5 mind that these rules did not apply to national
6 accrediting agencies.

7 CHAIRMAN BEARISON: So I think the question
8 is when we get back a draft of these rules, do
9 we want to leave that in there?

10 DR. TUCKER: I would like for it to be left
11 in there. Absolutely.

12 MR. TELLECHEA: Well, let me ask --

13 MS. MCNULTY: Do you want it to apply to
14 the national organizations? Is that what you're
15 saying?

16 DR. TUCKER: Yes.

17 MR. TELLECHEA: Let me ask you a question.
18 Okay. And it's kind of a round-about issue in
19 this regard. You said that you want the
20 surveyors to be ABMS or AAPS board certified or
21 AOA certified, right?

22 DR. TUCKER: Uh-huh.

23 MR. TELLECHEA: Do you want them to be
24 Florida licensed?

25 DR. TUCKER: I don't think they have to be

1 Florida licensed.

2 MR. TELLECHEA: Okay. All right. Because
3 if they're Florida licensed, then as Florida
4 licensed physicians they'd be obligated to
5 report it anyway.

6 DR. TUCKER: Yeah. I don't think --

7 MR. TELLECHEA: Okay. All right.

8 DR. ROSE: I think that would create a big
9 problem, the pool of people available.

10 MR. TELLECHEA: Okay. All right.

11 CHAIRMAN BEARISON: Dr. Winchester?

12 DR. WINCHESTER: They should be licensed in
13 some jurisdiction.

14 DR. TUCKER: Yes.

15 MR. TELLECHEA: Okay. I'll put that down,
16 licensed.

17 CHAIRMAN BEARISON: So if I'm not
18 misunderstanding, Committee member, what we've
19 said is that we want to leave that in.

20 DR. TUCKER: Uh-huh.

21 CHAIRMAN BEARISON: Correct?

22 DR. TUCKER: Yes.

23 CHAIRMAN BEARISON: And is that for any
24 group that we approve or only the ones that are
25 not nationally -- I guess they have to be --

1 MR. TELLECHEA: They all have to be
2 nationally recognized.

3 MS. MCNULTY: They're all national.

4 MR. TELLECHEA: Okay. The statute says you
5 have the authority to approve nationally-
6 recognized accrediting agencies.

7 CHAIRMAN BEARISON: So, in other words, if
8 they're not nationally recognized, when this
9 whole thing comes through and people apply to do
10 this, if they're not nationally recognized, then
11 we --

12 MR. TELLECHEA: Well, that's the -- the
13 number one requirement that is set by statute is
14 that they be nationally recognized.

15 CHAIRMAN BEARISON: Right. So if they're
16 not --

17 MR. TELLECHEA: If they are not nationally
18 recognized from the get-go they are not -- they
19 do not qualify.

20 DR. ROSE: And the definition of a national
21 recognition consists of what?

22 MR. TELLECHEA: Well, I would venture to
23 guess they would have to be recognized by more
24 than one -- at a minimum, they would have to be
25 recognized by more than one jurisdiction in the

1 United States, at a minimum.

2 DR. ROSE: Okay. Or have some sort of
3 status with the federal government?

4 MR. TELLECHEA: Something -- or something
5 like they have to show some kind of status that
6 goes outside of just one jurisdiction.

7 DR. ROSE: Okay.

8 CHAIRMAN BEARISON: Does anybody have any
9 other comments on that specific issue? (No
10 response.)

11 Okay.

12 DR. ROSE: Also, those national entities
13 would be required to report to us if they failed
14 their inspection or they withdrew their
15 accreditation immediately or things because
16 there could be something there that would
17 endanger the public. That would be part of what
18 we're talking about as well, correct?

19 MR. TELLECHEA: Well, that -- that is in
20 what we have for office surgery if you want to
21 retain that in there.

22 CHAIRMAN BEARISON: And I think we want to
23 because let's say if one of these agencies goes
24 in and inspects and finds something egregious, I
25 think that they need to be required to report

1 it.

2 MR. TELLECHEA: Well, there's that language
3 in there requiring them the reporting of the
4 potential threat to the public.

5 CHAIRMAN BEARISON: And then once you come
6 back with some language we can, you know,
7 revisit that again. But at least you'll have
8 some instruction from us to put it in there for
9 us to review it.

10 MR. TELLECHEA: Okay.

11 CHAIRMAN BEARISON: Okay. Ed, did you have
12 anything else that you think you would need? Or
13 did we give you enough meat, so to speak, to go
14 through this and adjust it and change it?

15 MR. TELLECHEA: Well, I -- I have some
16 guidance on it, but if there's anything else you
17 would like to provide, I would be happy to
18 listen to you.

19 CHAIRMAN BEARISON: Does anybody else have
20 any other comments?

21 MR. TELLECHEA: Can I suggest that we keep
22 the record open on this hearing for another five
23 days or seven days or whatever, so that if
24 somebody has -- wants to provide any information
25 regarding what was discussed today, they can go

1 ahead and do so in written format, and when we
2 have the draft of the rule next time, we can
3 take that into consideration when looking at the
4 draft.

5 CHAIRMAN BEARISON: We can do that. Do we
6 need to make a motion to that effect?

7 MR. TELLECHEA: Yes. For that, yes.

8 DR. ROSENBERG: So moved.

9 DR. TUCKER: So moved. Second.

10 UNIDENTIFIED SPEAKER: Second.

11 MR. TELLECHEA: How long is going to be
12 kept open?

13 DR. TUCKER: Five days.

14 MR. TELLECHEA: For five days.

15 DR. TUCKER: Five business days.

16 CHAIRMAN BEARISON: Five business days.

17 MR. TELLECHEA: Five business days. Okay.

18 CHAIRMAN BEARISON: Okay. All those in
19 favor? (Committee members responded.)

20 Opposed? (No response.)

21 Okay. So I think then at this point,
22 unless any Committee member wants to speak
23 anymore about this, we can kind of switch gears
24 at this point.

25 MR. TELLECHEA: And just to clarify,

1 there's some language in that rule that
2 basically allows the Board that they discover
3 that an accrediting agency is not meeting the
4 standards, they can issue an order to show cause
5 why they should not lose their accreditation
6 status.

7 I'm assuming that you want to maintain that
8 in there.

9 DR. TUCKER: Yes.

10 MR. TELLECHEA: You want to create some
11 type of mechanism so that if we find out that
12 they are not in compliance with our standards we
13 don't have to wait till they're -- till they're
14 accrediting period, which is, what, three -- no
15 more than three years ends.

16 We want to be able to go in there and
17 affirmatively take them down if they -- if we
18 have to. And when I mean "take 'em down," I
19 don't mean it.

20 (Laughter.)

21 I don't mean it "that" way.

22 CHAIRMAN BEARISON: Ms. Goersch?

23 MS. GOERSCH: Yeah. I just want to
24 clarify. Did we agree to that a clinic, using
25 Dr. Winchester's example of a new physician, he

1 wants to open up a clinic, that if -- if they
2 get a review -- I mean, they're not going to be
3 fully accredited with a patient -- I mean, are
4 we going to require -- what type of
5 accreditation are we going to require? Do we
6 need to be specific about that? Are we going to
7 use -- do you have a clear understanding of what
8 we were looking for there as far as --

9 MR. TELLECHEA: No.

10 MS. GOERSCH: -- as far as the type of
11 accreditation. Because I guess, you know, from
12 some testimony we heard anyway, there can be a
13 two phase or one phase, you know. What does
14 "accredited" mean?

15 Is somebody that you're in the process and
16 they sign a certificate saying, yeah, they're
17 accredited because they're going through the
18 process, or are we going to require that there
19 has been an inspection, that everything is done
20 except a patient records review.

21 Do we need to be specific on that? I just
22 want to be clear on it.

23 MR. TELLECHEA: Well, the statute says that
24 they have to be, you know, accredited by a
25 national accrediting agency. It doesn't say

1 anything about -- I would define accredited to
2 mean "fully" accredited, not provisional
3 accreditation or preliminary accreditation.

4 I don't know if you want to get into that
5 ball game.

6 CHAIRMAN BEARISON: And actually, in the --

7 MR. TELLECHEA: Here's the definition of --

8 CHAIRMAN BEARISON: -- it was brought to my
9 attention the definition is on the first page,
10 1(a), right under Definitions, (a) Accredited.

11 So the definition is there. We can --

12 DR. ROSENBERG: Full accreditation.

13 CHAIRMAN BEARISON: If -- if we want to use
14 that same definition.

15 MS. MCNULTY: But that also includes
16 provisional accreditation, I think, that goes to
17 Ms. Goersch's question, because I think we heard
18 the Joint Commission say "preliminary"
19 accreditation.

20 MS. GOERSCH: Yes.

21 MS. MCNULTY: So I think the first sentence
22 says "full accreditation" and it sounds like --
23 you have to tell us what you want in your rule.
24 You want it to mean only full accreditation, or
25 is provisional preliminary accreditation okay or

1 not?

2 MS. GOERSCH: Can I just follow up?

3 CHAIRMAN BEARISON: Ms. Goersch, do you
4 want to finish up?

5 MS. GOERSCH: Yes, I just want to follow
6 up.

7 So the question is are we going to drive
8 clinics to have to have a Board of Medicine, you
9 know, inspection the first time and then -- then
10 you can stay accredited later on?

11 It has to do with a patient records review,
12 if I understand right.

13 DR. WINCHESTER: They have one year?

14 MS. GOERSCH: Because full accreditation
15 would mean a patient records review, right?

16 DR. TUCKER: Uh-huh.

17 CHAIRMAN BEARISON: And they actually don't
18 even need -- again, I want to just remind
19 everybody, they don't even have to go through
20 all this and they don't even have to be
21 accredited.

22 They can just go through the Department of
23 Health inspection. If they think that's cheaper
24 and easier, then they can do that.

25 MS. GOERSCH: You're right. You're right.

1 CHAIRMAN BEARISON: And they don't even
2 have to deal with this.

3 MS. GOERSCH: So the question is, I mean,
4 are we setting it up that way, that if you're an
5 initial clinic you're going to have to get
6 accredited or go through the inspection process
7 with the Department and this is something for
8 later on?

9 MS. MCNULTY: Well, keep in mind the
10 statute says it's an annual inspection by the
11 Department, so it's not -- they're not inspected
12 before they get their registration.

13 MS. GOERSCH: And I think Mr. McPherson
14 said it's within the first year.

15 MS. MCNULTY: Right.

16 MS. GOERSCH: So do we want -- when do want
17 a pain clinic to be inspected? Do we really
18 want to say "before you open the doors you're
19 going to have to have at least a partial
20 accreditation."

21 I think we need to talk about that.

22 MS. MCNULTY: But I don't -- the statute
23 doesn't allow that. It says annual, so it
24 doesn't -- it doesn't require as a condition of
25 getting registration. I think that goes beyond

1 your statutory authority.

2 CHAIRMAN BEARISON: Mr. McPherson, can you
3 maybe help us with this a little bit?

4 MR. MCPHERSON: The situation would -- by
5 requiring full accreditation and not
6 provisional, temporary, et cetera, would --
7 would prevent a clinic from, at the end of 12
8 months or 9 months, and the inspector knocks on
9 the door saying, "well, we just submitted our
10 request for accreditation and that'll take six
11 months or however long."

12 And then at the end of that period when the
13 inspector comes by and you're not accredited,
14 they say "well, you know what, we've just
15 submitted to somebody else for accreditation."

16 So in terms of trying to enforce the fact
17 that somebody gets inspected once a year or
18 they're fully accredited, requiring full
19 accreditation and not provisional would be very
20 beneficial in enforcing this, and you are giving
21 people a year to make this happen.

22 CHAIRMAN BEARISON: Mr. Tellechea?

23 MR. TELLECHEA: Well, if you read the rule
24 regarding provisional accreditation, it says
25 "provisional accreditation," and you can use the

1 term "preliminary accreditation," I don't think
2 it matters whether it's preliminary or
3 provisional, it says that can only last for 30
4 days.

5 DR. ROSENBERG: Right.

6 MR. TELLECHEA: And at the end of the 30
7 days they have to demonstrate that they're in
8 full compliance.

9 So you're not going to have that issue -- I
10 mean, it's -- it wouldn't allow for a one-year
11 provisional accreditation or a one-year
12 preliminary accreditation.

13 DR. ROSENBERG: And that same rule also
14 says that it doesn't affect the quality of
15 patient care, so we're talking about relatively
16 minor issues that need to be corrected in 30
17 days.

18 I think the way this rule is drafted is
19 really quite nice.

20 DR. ROSE: Yeah. I agree.

21 CHAIRMAN BEARISON: Mr. Tellechea, how long
22 do you think it'll take to get this language to
23 us and that way we can discuss it in our next
24 meeting?

25 I know it's a loaded question. Because I

1 think our next meeting is when, Ms. Sanford?

2 MR. MCPHERSON: October 14th.

3 MS. SANFORD: October 14th.

4 MR. MCPHERSON: And did we set Orlando also
5 as the --

6 CHAIRMAN BEARISON: No, Tampa.

7 MS. SANFORD: Tampa.

8 MR. MCPHERSON: October 14th in Tampa.

9 CHAIRMAN BEARISON: So you'll be able to
10 get us some language in advance to review before
11 the meeting. At that meeting one of the things
12 we can do is to go over it and approve it. Does
13 that sound like a reasonable plan?

14 MR. TELLECHEA: We can certainly do that in
15 our spare time, yes.

16 (Laughter.)

17 MR. MCPHERSON: Just so -- just so I
18 understand, the rule will require national
19 organizations approved by this -- by the Boards
20 to notify us when somebody is accredited or if
21 there's a change in their status?

22 Let's say, for example, they're accredited
23 and then something happens and they drop down to
24 some other level. So we -- they have to tell us
25 when there's a change of status.

1 In terms of inspections, our -- you know,
2 the inspection program will be a little bit
3 different than what you would expect from
4 accrediting organizations. Because accrediting
5 organizations might go there like every three
6 years. Our inspections are every one year.

7 So when you say for purposes of
8 accreditation, the inspector needs to be board
9 certified in pain management.

10 That's going to be at a different level
11 from what we would do on inspections. Our
12 inspections may not have -- we may not have
13 board certified pain management people doing our
14 inspections of the records.

15 We're going to have a combination of people
16 who will be inspecting. But it may not include
17 a board certified pain management person for our
18 annual inspection.

19 So I don't want to think that -- that --
20 you know, that the level -- the level required
21 for this board certification is -- for the
22 accreditation is the same for our inspection.

23 And then with regard to deficiencies, we do
24 have -- the statute actually sets out what the
25 Department does or doesn't do when there are

1 deficiencies. We have to follow what the
2 statute says.

3 But is that -- is that clear with
4 everybody?

5 CHAIRMAN BEARISON: I had one, I guess,
6 question. So in essence then, the clinic has a
7 choice. They can be inspected by the Department
8 every year, correct? Or if they choose to get
9 accredited, the accreditation lasts for three
10 years?

11 MR. MCPHERSON: I think all of them say
12 three years.

13 MR. TELLECHEA: Three years.

14 UNIDENTIFIED SPEAKER: Two.

15 CHAIRMAN BEARISON: Two, whatever. But the
16 point being is that that's -- the clinic has a
17 choice. Every year it can get inspected by the
18 Department, pay the -- whatever fee we set up.
19 Was it 1,500 -- \$1,500. Or they can go ahead
20 and choose to be accredited and that
21 accreditation lasts whatever the agency says,
22 two or three years.

23 MR. TELLECHEA: Well, wait a second.

24 I mean, it's up to you folks as to how long
25 you want to have them be accredited.

1 Because all the statute says is that "the
2 Department shall inspect pain management clinics
3 annually, including the review of the patient
4 records, to ensure that it complies with this
5 section and rules of the Board of Medicine,
6 adopted pursuant to subsection (4), unless the
7 clinic is accredited by a nationally-recognized
8 accrediting agency approved by the Board of
9 Medicine."

10 That's all it says.

11 CHAIRMAN BEARISON: Well, that's --

12 MR. TELLECHEA: Your rules -- by rules, you
13 get to decide how often --

14 CHAIRMAN BEARISON: That's where --

15 MR. TELLECHEA: -- you know, how long the
16 accreditation is.

17 CHAIRMAN BEARISON: That's where I was kind
18 of going with this, just to kind of set the
19 stage, is what do we want to do with this?

20 In other words, do we want to go ahead and
21 say once you're accredited you're accredited for
22 two years, three years, whatever? Or are we
23 going to say you have be accredited every year?

24 MR. TELLECHEA: You -- what you're going to
25 be approving here is you're going to be

1 approving the crediting agency.

2 I don't know how long they accredit
3 entities for. I mean, I don't know if it's two,
4 three, four, five years or whatever it is. But
5 again, you've got to avoid -- I mean, you've got
6 to be sensitive about micromanaging how these
7 entities are going to accredit because, again,
8 you're going to just create a disincentive for
9 these entities to exist or to be involved in
10 this accrediting process.

11 CHAIRMAN BEARISON: So what you're saying
12 is once we approve the agencies, whatever --
13 however long their accreditation lasts for, then
14 we should just leave it at that?

15 MR. TELLECHEA: Well, I mean, that's
16 something you may want to consider, yes.

17 CHAIRMAN BEARISON: That seems to make
18 sense to me.

19 Ms. Goersch and Dr. Winchester.

20 MS. GOERSCH: If we look at the rules again
21 that we've been looking at here on the last
22 page, the last sentence says "an accreditation
23 period shall not exceed three years."

24 So maybe, again, we look at what --

25 MR. TELLECHEA: But again, this was for a

1 different -- this was not for nationally-
2 recognized accrediting agencies, these rules.

3 These rules were set up for the basically
4 new organizations that were being developed for
5 purposes of Florida office surgery
6 accreditation. All right.

7 This was not for the nationally-recognized
8 big entities that have been doing this for a
9 long time already that were basically approved
10 by statute.

11 MS. GOERSCH: Well, I guess then I would
12 express some discomfort in if one of the
13 accrediting agencies decided to say, well, it's
14 good for -- I come in and inspect and it's good
15 for ten years.

16 You know, I guess unless they're going to
17 come back and inspect it -- I guess the
18 protection would be to require the same
19 standards as ours, which I think we agreed to
20 put in there. Then they would have to be
21 inspected at least annually.

22 CHAIRMAN BEARISON: Well, one thing we can
23 put in the rule is, you know, no more than three
24 years, at least, would be something.

25 Dr. Winchester, I think you've had much

1 more experience in this than I do, so go right
2 head, sir.

3 DR. WINCHESTER: You know, we have
4 representatives from a couple of the national
5 companies here, and I don't want my comments to
6 sound, you know, mean or evil towards them.
7 However, those groups are charging a fee for
8 having inspections done. And I somehow doubt
9 that they are going to allow a ten-year
10 timeframe.

11 And don't take that wrong --

12 (Laughter.)

13 -- but, you know, I'm just, you know, being
14 realistic about this.

15 So, you know, the concept of seven or ten
16 years I don't think you're going to see.

17 CHAIRMAN BEARISON: All right.

18 Dr. Rosenberg and then Dr. Tucker.

19 DR. ROSENBERG: The various groups that
20 have testified today, the longest one was three
21 years. So I'm not sure that is really an issue.

22 CHAIRMAN BEARISON: Dr. Tucker?

23 DR. TUCKER: Could we not put in the rule
24 that if a clinic chooses to be accredited they
25 must do so every three years?

1 UNIDENTIFIED SPEAKER: Uh-huh.

2 DR. TUCKER: And then that doesn't affect
3 the accrediting agency; it just affects the
4 clinic.

5 UNIDENTIFIED SPEAKER: Uh-huh. I agree
6 with that.

7 CHAIRMAN BEARISON: I think that may solve
8 the problem. Any other thoughts?

9 DR. TUCKER: He's looking -- yeah, he's got
10 a look.

11 MR. TELLECHEA: I'm thinking about that.

12 CHAIRMAN BEARISON: Well, put it in. We
13 can --

14 MR. TELLECHEA: I'll put that in as an
15 option but let me look into it.

16 CHAIRMAN BEARISON: Okay.

17 MR. TELLECHEA: Because, you know, there's
18 a fine line between approving and accrediting
19 agency as opposed to setting -- as opposed to
20 standards for the office surgery clinic to be
21 accredited.

22 That may be beyond the scope of the
23 rulemaking authority. But let me look into it
24 and I'll -- and I'll provide that option in the
25 rules. Okay?

1 DR. TUCKER: Okay.

2 CHAIRMAN BEARISON: All right.

3 DR. ROSE: Well, couldn't one of those
4 standards you look at in approve these national
5 agencies is that they are in a cycle that does
6 not exceed three years?

7 MR. TELLECHEA: Well, maybe as to how it's
8 written is what may be the case.

9 CHAIRMAN BEARISON: Mr. Tellechea, do you
10 have any other questions for us about what you
11 need to know to come back with some draft
12 language for us?

13 MR. TELLECHEA: No.

14 CHAIRMAN BEARISON: Ms. McNulty?

15 MR. TELLECHEA: Donna? Nancy? Do you have
16 anything else?

17 MS. MCNULTY: I'm sorry.

18 CHAIRMAN BEARISON: Do you kind of get the
19 idea of what we want to do?

20 MR. TELLECHEA: I mean, they want to know
21 -- I mean, I've -- I've got some input here,
22 written notes.

23 MS. MCNULTY: I've got input, too.

24 MR. TELLECHEA: I mean, unless there's
25 anything else you want to let us know.

1 CHAIRMAN BEARISON: Okay. Mr. McPherson,
2 do you want to add anything or can we kind of
3 switch gears?

4 MR. MCPHERSON: Let's switch.

5 CHAIRMAN BEARISON: Okay. This part of the
6 conversation is closed.

7 Now we're going to switch -- formally
8 switch gears and the issue -- the second issue
9 and final issue, which we'll stay focused on and
10 discuss, is the number of prescriptions.

11 So, Mr. McPherson, I know you shuffled the
12 deck --

13 MR. MCPHERSON: Right.

14 CHAIRMAN BEARISON: -- so let's go ahead.
15 And, again, I'm going to ask everybody to limit
16 themselves to specifically that and hopefully no
17 more than five to eight minutes.

18 MR. MCPHERSON: Members, you have in your
19 materials, either in paper or on the disk,
20 you've got materials submitted in Book 2, Tabs
21 18 through 24, from Dr. Tracy, Mr. Sloan,
22 Dr. Bassoon (ph), Mr. Perado (ph), Chris Nuland,
23 Dr. Miguel, and Dr. Emami (ph), Dr. Emami.

24 I would ask you during the course of this,
25 as the Chair said, this is really a focused

1 discussion of how to implement what the
2 legislature has told the two Boards to do. And
3 the legislature said the two Boards shall
4 develop a rule that places a limit on the number
5 of controlled IIs and IIIs and Alprazolam that
6 can be written at a pain clinic during a 24-hour
7 period.

8 So the legislature has tasked the Boards
9 with doing that. So I know some of the material
10 you've received are comments about whether or
11 not the legislature should have taken a
12 different approach. That really is not an issue
13 that this Joint Committee can address. We can
14 address to implement what the legislature says
15 we're to do.

16 So -- and some of the materials -- in fact,
17 four of the presenters actually give you some
18 suggested formulas on -- which I think is a real
19 good approach for you to start with.

20 So I've shuffled the deck here, and -- so
21 the first one is Charles Chase.

22 Mr. Chase, did you wish to speak on that
23 24-hour limit on the number of control
24 substances?

25 DR. CHASE: Just briefly.

1 CHAIRMAN BEARISON: Go right ahead, sir.

2 Mr. Tellechea, do the speakers who spoke
3 already need to be sworn in again?

4 MR. TELLECHEA: No. If you've been sworn
5 in once, you're still under oath.

6 CHAIRMAN BEARISON: Okay.

7 DR. CHASE: My name is Charles Chase,
8 speaking on behalf of the Florida Society of
9 Anesthesiologists and Dr. Miguel.

10 It is the opinion of our Society that we
11 should have a limit of two controlled substance
12 prescriptions written per patient, per day for
13 the clinic, but with a caveat that that doesn't
14 include if a prescription is written for a
15 second or third month.

16 Most of these patients are seen every three
17 months for their follow up and what we're hoping
18 is that you wouldn't include the second- and
19 third-month prescriptions as part of that total
20 that can be written per day.

21 If it was -- however it's written, if it
22 needed to be written that any prescriptions that
23 are written that day are included, we would
24 endorse a bigger limit of six, per day, per
25 person per day. If it included those

1 prescriptions that were written for subsequent
2 months.

3 MR. MCPHERSON: For me to understand this
4 --

5 DR. CHASE: Right.

6 MR. MCPHERSON: -- your formula is during a
7 24-hour period at a pain clinic, one doctor can
8 write during an eight-hour period how many
9 prescriptions?

10 DR. CHASE: Two prescriptions per patient
11 per day.

12 MR. TELLECHEA: That's not what it says.

13 MR. MCPHERSON: Okay. The law says we have
14 to come up with how many prescriptions can be
15 written in a 24-hour period by the clinic.

16 So in a 24-hour period do you have a
17 suggestion on how the Board could arrive at that
18 number?

19 DR. CHASE: Our suggestion would be two per
20 person, per day. But if subsequent months are
21 included --

22 MR. MCPHERSON: Okay.

23 DR. CHASE: -- in that count --

24 MR. MCPHERSON: So if -- if it's possible
25 that there's a hundred people running through,

1 so it's two times a hundred people in one day
2 would be 200 a day?

3 DR. CHASE: Yes.

4 MR. MCPHERSON: Okay.

5 DR. CHASE: But not everybody gets
6 prescriptions. Not every, you know, legitimate
7 pain clinic has every patient that they see only
8 on prescriptions. So there's a little fudge
9 factor in there that, you know, maybe --

10 CHAIRMAN BEARISON: Okay.

11 DR. CHASE: -- 50 or 75 percent of your
12 patients are being written multiple
13 prescriptions.

14 CHAIRMAN BEARISON: Committee members?
15 Dr. Tucker, then Dr. Rosenberg.

16 DR. TUCKER: I have a question for, I guess
17 it's for Mr. Tellechea or Mr. McPherson.

18 By the way the statute is written, are we
19 going to have to have a number or can we use a
20 formula?

21 MR. TELLECHEA: Yes.

22 (Laughter.)

23 CHAIRMAN BEARISON: See, that's real
24 helpful.

25 DR. TUCKER: Okay. Mr. McPherson, I'll try

1 you.

2 MR. MCPHERSON: My suggestion is for,
3 during today, is to gather information on how
4 many patients could a physician see during a
5 day, during like the typical eight-hour day, how
6 many pain clinic patients could be seen by a
7 pain clinic physician who's writing scripts if
8 that pain clinic physician is doing everything
9 that the law and the rules say they should be
10 doing with each and every patient.

11 And then once you arrive at that, then I
12 think you can then go from there in how you want
13 the rule crafted. That's probably one way to
14 approach this, is look at -- look at it that
15 way.

16 DR. TUCKER: If I can ask a follow-up
17 question to Dr. Chase, average of pain patients
18 seen per day by one physician?

19 DR. CHASE: Thirty to 40 --

20 DR. TUCKER: Thirty to 40. So 35 would be
21 --

22 DR. CHASE: -- can visit a pain clinic.

23 DR. TUCKER: -- okay. All right.

24 So, in other words, by your formula, that's
25 70 prescriptions for that month.

1 DR. CHASE: For that day.

2 DR. ROSENBERG: No, for the day.

3 DR. TUCKER: For the -- for that day. But
4 I guess what I'm trying to say is that you had
5 the caveat of the two per patient, but that was
6 for that month that the patient was being seen?

7 DR. CHASE: Right.

8 DR. TUCKER: Okay. So in other words, for
9 the ones that are written out for the two and
10 three months, I guess we would have to word that
11 a little different way.

12 DR. CHASE: If it was for a continuation of
13 the same drug --

14 DR. TUCKER: Uh-huh.

15 DR. CHASE: -- we would suggest not
16 including that in the count. That these
17 illegitimate pain clinics, the ones that are
18 just pill mills, they're writing a prescription
19 for essentially like one month and they're
20 making people come back so they can charge them
21 office visit.

22 DR. TUCKER: Uh-huh.

23 DR. CHASE: And so other pain clinics that
24 are more the norm are writing out, say, for
25 three months' worth. So they're giving a

1 patient, say, the prescription that says "do not
2 fill until one month from today."

3 DR. TUCKER: Okay.

4 DR. CHASE: And another one "two months
5 today."

6 DR. TUCKER: So in other words, you're
7 saying rough -- a good average would be 70
8 prescriptions per doctor per day.

9 DR. CHASE: Yes.

10 DR. TUCKER: Okay.

11 CHAIRMAN BEARISON: Short-term memory loss
12 here. I'm just going to go right down the line
13 here, so if somebody raised their hand first, I
14 apologize.

15 Ms. Goersch?

16 MS. GOERSCH: So with the change of a
17 physician having to perform a physical exam, do
18 you think that count is going to reduce from 30
19 to 40 patients being seen a day by the
20 physician? Is it going to reduce less?

21 DR. CHASE: Probably not. They must just
22 have to work longer hours to be able to get in
23 all the paperwork, but it's (unintelligible)
24 reduce the number of people that are going to be
25 able to be seen per day (not using microphone).

1 MS. GOERSCH: Thank you.

2 CHAIRMAN BEARISON: Dr. Winchester?

3 DR. WINCHESTER: I was wondering, in the
4 definition section if we could define a
5 prescription such that the two refills count as
6 one prescription.

7 There should be some way we can put that in
8 as a definition. And that would -- because I
9 think that's a very important -- important part
10 of the process.

11 DR. CHASE: Our recommendation would hinge
12 upon how those subsequent prescriptions are
13 viewed. If they're viewed as additional
14 prescriptions that are written on that day, we
15 would support a higher limit.

16 MR. TELLECHEA: You know, this statutory
17 provision is addressing -- is asking for a
18 simple solution to an extremely complicated
19 issue. And I think just these issues that we're
20 talking about right now raises how difficult --
21 you know, how hard of a nut this is to crack,
22 you know.

23 Because there's a definition of what
24 constitutes a prescription. You know, this --
25 this -- given in terms of, you know, how many

1 prescriptions can be issued by a pain clinic,
2 but what happens if you've got a pain clinic
3 that's got 20 doctors?

4 MS. GOERSCH: Yeah.

5 MR. TELLECHEA: You know, it's -- so I
6 think almost by definition, if you're going to
7 give an answer to this question that's been
8 raised by the legislature, I think you're going
9 to have to do it by physician.

10 DR. WINCHESTER: Uh-huh.

11 MR. TELLECHEA: Because otherwise, then
12 it's irrelevant and it means nothing for
13 purposes -- or otherwise what it's going to do
14 is it's going to restrict the number of doctor
15 that can work in any one pain clinic one way or
16 another.

17 DR. WINCHESTER: Uh-huh.

18 CHAIRMAN BEARISON: Dr. Rosenberg?

19 DR. ROSENBERG: When this came to the Rules
20 and Legislative Committee, it was strongly
21 opposed. Unfortunately now we have to deal with
22 something that, as I think everybody here
23 recognizes, as an impossible task.

24 Obviously one of our concerns is to make
25 sure that the patients are protected. And by

1 coming up with an arbitrary number, based on 35
2 or 40 patients per day, what happens when the
3 41st patient shows up and is in need of
4 appropriate pain relief.

5 I would be concerned that an arbitrary
6 number is going to be potentially dangerous.
7 And I think using a formula per doctor, per
8 patient, would be a little bit safer. There may
9 be doctors who work ten-hour days. There may be
10 doctors who will work only five-hour days and
11 abuse an absolute number.

12 So I -- I'd rather see a formula and then
13 if somebody in the legislature thinks that
14 that's not appropriate, let them, you know,
15 address it further.

16 CHAIRMAN BEARISON: Mr. McPherson?

17 MR. MCPHERSON: (Shakes head.)

18 CHAIRMAN BEARISON: Okay. Let me go over
19 to this side.

20 I'm sorry, Dr. Burns. I can never see you.

21 VICE-CHAIR BURNS: No. No questions.

22 CHAIRMAN BEARISON: So please don't
23 hesitate to throw a spit-ball at me.

24 MR. MCPHERSON: Thank you, Mr. Chase.

25 CHAIRMAN BEARISON: Thank you.

1 MR. MCPHERSON: Dr. Nadler, did you wish to
2 speak on this --

3 MS. SANFORD: Natal.

4 MR. MCPHERSON: Natal. Dr. Natal, did you
5 wish to speak on this issue? (No response.)

6 Apparently not.

7 DR. NATAL: No, not at this time. Thank
8 you.

9 MR. MCPHERSON: Okay. Next is Lennie
10 Duensing --

11 MS. SANFORD: Duensing.

12 MR. MCPHERSON: -- Duensing. Did you wish
13 to speak on this issue? Lennie Duensing?

14 MR. DUENSING: I think the only comments we
15 have are regarding the accreditation.

16 MR. MCPHERSON: Okay.

17 MR. DUENSING: I'm not sure how those --
18 (not using microphone).

19 MR. MCPHERSON: All right. Sir, I'm just
20 being prudent.

21 MR. DUENSING: Okay.

22 MR. MCPHERSON: Belt and suspenders, but
23 actually all I have on is suspenders today.

24 MR. DUENSING: Uh-o.

25 MR. MCPHERSON: Dr. Dennison, did you wish

1 to speak on this issue?

2 DR. DENNISON: Yes.

3 CHAIRMAN BEARISON: Please be sworn in,
4 sir.

5 THE REPORTER: Do you swear or affirm the
6 testimony you will give here today will be the
7 truth, the whole truth, and nothing but the
8 truth?

9 DR. DENNISON: I do.

10 THE REPORTER: Thank you.

11 CHAIRMAN BEARISON: Thank you.

12 DR. DENNISON: Members of the Board, I
13 appreciate your taking my comments.

14 Originally, I was going to say that I don't
15 believe that there should be any limit, and per
16 patient. Each patient is so different with each
17 individual problems that they have. And when
18 you limit the number of patients' prescriptions,
19 even in the clinics, and some of these clinics
20 we do see patients with cancer, not just
21 nonmalignant pain.

22 I find it very difficult to put a limit on
23 what you're going to treat the patient for.
24 Typically, everyone's rationalized on what their
25 treating their patients with, and that is,

1 again, your physicians that have done
2 fellowships in pain that have been trained in
3 pain and see also patients in the hospitals.

4 I would -- I would surmise to you that any
5 physician that has been practicing pain
6 management should not have a limit on how much
7 prescriptions he prescribes.

8 That's my comment.

9 MR. MCPHERSON: Thank you.

10 CHAIRMAN BEARISON: Any comments or
11 questions from members of the Committee? (No
12 response.)

13 MR. MCPHERSON: Okay.

14 CHAIRMAN BEARISON: Okay. Mr. McPherson?

15 MR. MCPHERSON: Thank you.

16 CHAIRMAN BEARISON: Thank you.

17 DR. DENNISON: Thank you.

18 MR. MCPHERSON: Just let me restate for
19 everybody's benefit, the purpose of this
20 Committee is to comply with what the legislature
21 has tasked the Committee with, and that is to
22 come up with a number. So although comments,
23 we've seen written comments and now have heard
24 oral comments that people may not agree with
25 that, we are not at the point of discussing

1 whether or not the legislature might have taken
2 a different tact.

3 We are at the point of discussing how do we
4 arrive at the appropriate number, what factors
5 should we be considering. And so far we've --
6 we've looked at the number of physicians, that's
7 one thing we need to look at.

8 We need to look at how should we treat
9 refills. They should be treated -- you know,
10 the number should reflect refills or no refills.

11 So I'm thinking those kind of comments
12 would probably be most helpful for the
13 Committee.

14 Dr. Cordner, did you wish to speak on this
15 issue?

16 DR. CORDNER: (Nods head.)

17 THE REPORTER: Do you swear or affirm that
18 the testimony you give here today will be the
19 truth, the whole truth, and nothing but the
20 truth?

21 DR. CORDNER: Yes.

22 THE REPORTER: Thank you.

23 DR. CORDNER: I did submit a written
24 comments to the Board of Medicine earlier, so I
25 would appreciate the review of that.

1 A few things. The word "refills" was sent
2 around. And again, remembering that most
3 controlled IIs cannot be refilled. But you can
4 be given a prescription for a second and third
5 subsequent month. So, again, the wording of
6 that, however you do it, just be very careful
7 with that, that's it not included as a refill.

8 The other thing that was a concern to me as
9 I went through this, is that the AHCA rules and
10 regulations that were adopted by the Board of
11 Medicine specifically addressed the number of
12 prescriptions being written and that they would
13 not mandate limits on prescriptions written for
14 patients, and specifically under the guidelines
15 of controlled substances and dangerous
16 substances prescription.

17 And that wording is in the AHCA, as well as
18 the Board of Medicine adoption of that. So this
19 -- this requirement by the legislation lies in
20 contradictory to your present policies there.
21 So I just want to make you aware of that.

22 And again, the same things the people have
23 come up with. If a pain clinic has one
24 physician versus ten, that is going to really
25 vary tremendously. So putting an absolute one

1 number -- I agree with Dr. Rosenberg
2 wholeheartedly about applying a formula. I
3 think that really needs to be done on a per
4 patient, per physician basis.

5 With respect to the Florida Society of
6 Anesthesiologists, I think restricting it to two
7 per patient is not enough. Certainly we have
8 many-many patients, especially cancer patients,
9 that are given more than two prescriptions, and
10 that's very common in an everyday practice to be
11 two.

12 If the Board is going to be mandated to
13 come up with a limited number, I think it has to
14 be very generous. I understand the -- the
15 concerns that the legislation had with doing
16 this, and especially spilling out Xanax, but all
17 the other -- I think we're losing the forest for
18 the tree here sometimes, is you have other
19 regulations. You have other things. Looking at
20 shutting down pill mills and the absolute number
21 is going to affect legitimate patients, and we
22 really need to do that.

23 We're definitely in a quandary here as to
24 what the number should be. If I were going to
25 adopt a number, I would make it generous, so

1 that people, legitimate patients like the 41st
2 patient, doesn't get effected. And I would at
3 least recommend a number of five per patient,
4 per physician per day.

5 CHAIRMAN BEARISON: Thank you. Committee
6 members? (No response.)

7 MR. MCPHERSON: Thank you, Doctor.

8 CHAIRMAN BEARISON: Dr. Winchester and
9 Dr. Rosenberg.

10 DR. WINCHESTER: I was just thinking of
11 making a stab at the definition, and that a
12 prescription be defined as a written
13 prescription per 24 hours that may include up to
14 two predated prescriptions of the same
15 medication.

16 MR. TELLECHEA: Can you read that again?

17 DR. WINCHESTER: A prescription is defined
18 as a written prescription for 24 hours that may
19 include up to two predated prescriptions of the
20 same medication.

21 That gives the quote "refills", which are
22 not --

23 MR. MCPHERSON: That's up to two what? Up
24 to two?

25 MS. SANFORD: Predated.

1 DR. WINCHESTER: Predated.

2 MR. MCPHERSON: Predated.

3 DR. WINCHESTER: Predated prescriptions of
4 the same medication.

5 MR. TELLECHEA: Okay. But I -- whatever I
6 would do I would also -- because there are other
7 definitions of prescription and statute, for
8 instance, the Board of Pharmacy has a
9 definition, I would say for purposes of this
10 rule only --

11 DR. WINCHESTER: That's what I said.

12 MR. TELLECHEA: Okay. It's the psychic
13 connection we have.

14 DR. ROSENBERG: Are you legally allowed to
15 predate prescriptions?

16 DR. ROSE: No. I don't think we want to
17 use the "predate". Maybe --

18 MR. TELLECHEA: Pardon me?

19 DR. ROSE: I don't know if we want to use
20 that word "predate". Maybe issue two
21 prescriptions with "do not fill" before dates.

22 CHAIRMAN BEARISON: I don't think you're
23 allow to provide a prescription with a wrong
24 date.

25 MR. TELLECHEA: I think you -- I think it's

1 what Dr. Rose said. You can go ahead and say
2 "this prescription shall not be filled before
3 so-and-so date."

4 DR. ROSE: You've got to put the current
5 day that you're writing the prescription, but
6 you may put on there "do not fill this
7 prescription before such date".

8 DR. ROSENBERG: Okay.

9 DR. ROSE: So it's like a do-not-fill date.

10 CHAIRMAN BEARISON: Okay. Thank you.

11 Mr. McPherson?

12 MR. TELLECHEA: I know what you're talking
13 about and I can write something to include that.

14 DR. ROSE: Okay. Thank you.

15 DR. ROSENBERG: I have a question, though,
16 for the doctor.

17 CHAIRMAN BEARISON: Do you have a question
18 for him?

19 DR. ROSENBERG: Yes. What percentage of
20 the patients in your practice need five
21 prescriptions?

22 DR. CORDNER: Not a large percentage at
23 all, but there are. I mean, you know, take in
24 mind that we have patients that have terminal
25 cancer.

1 CHAIRMAN BEARISON: Well, let me interrupt
2 you. Again, remember, this is for chronic
3 nonmalignant pain.

4 DR. ROSENBERG: Right.

5 CHAIRMAN BEARISON: So my understanding,
6 correct me if I'm wrong, Mr. Tellechea, this
7 wouldn't apply, correct?

8 DR. CORDNER: No. Because my clinic treats
9 other than chronic malignant pain. So those
10 rules still apply to me, even if 20 percent of
11 my patients have malignant pain. That rule of
12 number of prescriptions still applies to my --

13 CHAIRMAN BEARISON: Mr. Tellechea?

14 MR. TELLECHEA: No. Because the -- the
15 Board's setting forth standards of practice for
16 physicians prescribing in privately-owned pain
17 management clinics that primarily engage in the
18 treatment of pain by prescribing or dispensing
19 control-substance medications.

20 And then they define "primarily engage in
21 the treatment of pain by prescribing or
22 dispensing controlled..." I don't think those
23 -- I mean, I don't know, Donna, what you think.

24 I don't know if those standard of practice
25 rules would apply to situations for -- when

1 people are treating chronic nonmalignant pain.

2 DR. CORDNER: The majority of my patients
3 are not chronic -- are not cancer pain.

4 My clinic still falls under the regulation
5 because I treat nonmalignant pain. But if I
6 have a patient that does have malignant pain,
7 I'm still held to the same standards for all of
8 those patients.

9 DR. WINCHESTER: Yes.

10 MR. TELLECHEA: I'm not sure that's the
11 case. I'd have to take a look at that.

12 CHAIRMAN BEARISON: Mr. Tellechea, I guess
13 the question is would this prescription count?

14 MR. TELLECHEA: I'm not sure. I don't
15 think so. I mean, off the top of my head I
16 don't think it does, but, you know, I'll have to
17 read it.

18 MS. MCNULTY: We will take it back under
19 advisement and --

20 MR. TELLECHEA: Yeah, we'll take it under
21 advisement.

22 DR. ROSENBERG: I wanted to follow up on
23 that -- on that question though.

24 So it's a small percentage that are five.
25 What about four? Is that also a small

1 percentage?

2 DR. CORDNER: That's fairly regular. I
3 mean, remember, controlled substances could be
4 -- you know, things like Lyrica, things like
5 that that are not specifically --

6 DR. ROSENBERG: I mean, the reason I'm
7 saying this -- I think we can come up with, say,
8 something that an average of, rather than coming
9 up with a -- you know, because five seems
10 excessive and somebody's going to question what
11 is the Board thinking. And if we, you know,
12 whether it's three or four, but we said that the
13 average per patient, per doctor, per day is a
14 number, that's a little more conservative than
15 five.

16 I think that that might be more
17 appropriate. That's just my impression.

18 CHAIRMAN BEARISON: Dr. Rose?

19 DR. ROSE: Maybe that might help with --
20 Mr. Tellechea, when they develop the rule you
21 can say for the purpose of this rule, these --
22 this prescription limit does not include for
23 those patients in the clinic who receive
24 medication for malignant pain.

25 I don't know if that would help in your

1 definition.

2 But it kind seems to me the direction we're
3 going to is we're going to look at a number of
4 prescriptions per doctor, per patient, per day
5 as a formula and that number may be somewhere
6 between three to four, not including the
7 do-not-fill beyond dates, because a lot of
8 patients will perhaps -- and correct me if I'm
9 wrong -- receive some type of longer-acting
10 opioid medication. Maybe some kind of
11 short-acting opioid for a breakthrough. Some
12 type of anxiolytic or muscle relaxer that could
13 or could not be a controlled drug. And maybe
14 not a Schedule II or III, but a Schedule IV when
15 the neuroleptic agents, like Lyrica or something
16 that controls neuropathic pain, but is still a
17 controlled medication.

18 So that's kind of see where we're at at
19 this point.

20 CHAIRMAN BEARISON: Dr. Tucker.

21 DR. TUCKER: I thought -- doesn't the
22 statute say for two and three drugs and Xanax.
23 So it would only be limited to those. The Is
24 and IVs and whatever else we have.

25 MR. TELLECHEA: It's Schedule II and III

1 and Xanax.

2 DR. TUCKER: Schedule II and III. Okay.
3 Okay.

4 DR. ROSE: So then it would be like III
5 probably, II or III, III at most.

6 CHAIRMAN BEARISON: Okay. Mr. McPherson, I
7 think we're ready for the next speaker.

8 MR. MCPHERSON: The next -- thank you.
9 Thank you, Doctor.

10 The next speaker is Mr. Chris Nuland. Did
11 you wish to speak on this?

12 MR. NULAND: Yes, please.

13 Good morning. Just to follow up on
14 Dr. Cordner's comments with which we agree, the
15 Florida Academy of Pain Medicine.

16 I'm quoting from Section 4(c) of the
17 statute, just so everyone's on the same page.

18 "The Board of Medicine shall adopt a rule
19 establishing the maximum number of prescriptions
20 for Schedule II or Schedule III controlled
21 substances, or the controlled substance
22 Alprazolam, which may be written at any one
23 registered pain management clinic during a
24 24-hour period."

25 So unfortunately, I believe that the way

1 the statute is written, even if it's written for
2 a chronic malignant pain, that still would be
3 covered in this, as long as it's written in a
4 pain clinic.

5 That being said, what the Florida Academy
6 of Pain Medicine would like to propose to you,
7 and I think they're seems to be a consensus, is
8 that a pure limit per clinic is inappropriate
9 because clinics have different numbers of
10 patients, different numbers of physicians.

11 The Florida Academy of Pain Medicine is
12 also very concerned that having a strict limit
13 of prescriptions per patient doesn't recognize
14 the differing needs of different patients. And
15 I think Dr. Cordner's eloquently stated that, as
16 did Dr. Rose, just a few moments ago how a
17 normal pain patient may indeed have four
18 different prescriptions when they leave.

19 So how do we correct this? We believe that
20 a reputable, honest pain physician treating a
21 new patient has got to spend at least 15 minutes
22 with that patient. Therefore, in a ten-hour
23 day, you should only be able to see and write
24 new prescriptions for 40 patients.

25 Now we're very sensitive also to that 41st

1 patient. So what we would like to put forth is
2 that it be measured not necessarily on a
3 day-by-day basis, so an inspector could come in
4 and say "on this day you wrote to 41," but it be
5 averaged, whether it be weekly or monthly, so
6 that you can have an average of 40 a day per
7 week. And it allows for the 41st patient, but
8 you can't do it as a regular practice.

9 Finally, making it for new prescriptions,
10 new patients, I think recognizes the same issues
11 that we've been working with over the last 30
12 minutes as to what do you do, whether you call
13 them refills or predated, however you want to do
14 that, but setting the limit on new prescriptions
15 is what you need.

16 CHAIRMAN BEARISON: And the number you are
17 recommending is?

18 MR. NULAND: We --

19 CHAIRMAN BEARISON: What does the statute
20 say? We need a number?

21 MR. NULAND: Number? We would say that no
22 less than five, and that if you assume that 40
23 patients are seen a day, my math says 200 a day.

24 CHAIRMAN BEARISON: Okay. Thank you.

25 Members of the Committee, questions?

1 Dr. Rose?

2 DR. ROSE: The only thing that I notice
3 through the cases that I've seen that have been
4 problems, it's not always the number of
5 prescriptions; it's the quantity of pills that
6 they receive per prescription which are -- and
7 this is not even addressing that. So they could
8 meet this, but they could write them 540 pills
9 of OxyContin, 30 milligrams.

10 I mean, that's -- these are the kinds of
11 things we see that end up being administrative
12 complaints and final orders being filed.

13 MR. NULAND: There are also -- to go to
14 that point, if I may, for the Chair?

15 CHAIRMAN BEARISON: If it's very focused.

16 MR. NULAND: Very focused. When the
17 databank gets established, hopefully in
18 December, inappropriate prescribing will
19 continue to be inappropriate prescribing, and
20 hopefully a pharmacist will be able to see an
21 clearly inappropriate prescription, and either
22 report it or do what, in his professional
23 judgement is needed, and not fill that
24 prescription.

25 CHAIRMAN BEARISON: Mr. Tellechea?

1 MR. TELLECHEA: When you draft this rule
2 up, you need to put some language in there that
3 says that this -- that in no way does this
4 restriction supercede the standard of care for
5 prescribing controlled substances that are
6 applicable to all physicians in the state of
7 Florida.

8 You need to put something like that also,
9 so that cannot be used as a defense for the
10 situation that you just raised.

11 MR. NULAND: And we would agree with that.

12 CHAIRMAN BEARISON: Other members of the --
13 Dr. Winchester?

14 DR. WINCHESTER: I hate to beat this to
15 death, but going back to the prescriptions with
16 the do not fill, it seems like the -- and the
17 pain folks know this a lot better than me, but
18 it seems like that ruling came out in the spring
19 a year-and-a-half ago. I'm not -- that's what
20 somehow I remember.

21 But anyway, we could go to the FDA and
22 just, you know, mimic the language that the FDA
23 used to define those prescriptions with "do not
24 fill".

25 MR. TELLECHEA: We'll do that.

1 CHAIRMAN BEARISON: Dr. Burns?

2 VICE-CHAIR BURNS: Just for clarification,
3 when you speak in terms of not less than five
4 prescriptions for patients, are you including
5 the ones filled that month as well the second
6 and third month, in that number five?

7 MR. NULAND: Considering as been put forth,
8 the second and third month be considered one
9 prescription.

10 VICE-CHAIR BURNS: Okay. So that five
11 prescriptions would include up to the
12 three-month interval.

13 MR. NULAND: Yes.

14 CHAIRMAN BEARISON: Dr. Rosenberg?

15 DR. ROSENBERG: When you said "new
16 patients," do you mean -- or "new prescriptions"
17 rather, were you referring to new patients that
18 would be 15-minute evaluations?

19 I mean, there are patients who come back
20 for their follow up in three months. Are you
21 excluding them in your calculations?

22 MR. NULAND: In the calculations that we
23 did, yes, we excluded those because existing
24 patients coming in for routine follow ups may
25 not need that full 15 minutes. But that,

1 honestly, got into another discussion that we
2 did not have a good answer for.

3 DR. ROSENBERG: So your calculation for the
4 number of prescriptions is really only for new
5 patients, and the actual absolute number per day
6 in that facility may be significantly higher; is
7 that what you're saying?

8 MR. NULAND: Potentially, but we did not
9 reach a number for that.

10 DR. ROSENBERG: All right. So we really
11 can't just use this number as an absolute, even
12 if we were thinking of doing that because it
13 would exclude an awful lot of other patients and
14 the legislature wants us to deal with because
15 they didn't specify new -- new patients as a
16 problem.

17 MR. NULAND: I will concede that.

18 CHAIRMAN BEARISON: Thank you very much,
19 sir.

20 I'm sorry. Dr. Rose, did you want --

21 DR. ROSE: Not for him, but when we get to
22 someone else that's a clinician actually
23 practicing, maybe we can ask them to comment on
24 a new patient, if they're able to obtain and
25 review all old prior to records, obtain a

1 complete history of all treatments they received
2 in the past and how effective they were and
3 conduct a complete physical examination and
4 write the prescriptions and document everything,
5 and that that can all be done in 15 minutes for
6 a new patient. And then I'd like -- or how long
7 it takes them to do that. And I'd like to hear
8 what exactly they do on the follow-up visit and
9 conducting the exam and how long it takes them
10 to do that and document that, so we get some
11 idea of someone who's actually doing this and
12 how long it takes.

13 Fifteen minutes sounds like a very quick
14 time to do all that we're requiring them to do
15 for a new patient, to me.

16 CHAIRMAN BEARISON: Mr. McPherson?

17 MR. MCPHERSON: Thank you. Dr. Tracy is
18 the next speaker.

19 CHAIRMAN BEARISON: Maybe Dr. Tracy can
20 shed some light on that, because I know that's
21 what she does.

22 THE REPORTER: Do you swear or affirm that
23 the testimony you give here today will be the
24 truth, the whole truth, and nothing but the
25 truth?

1 DR. TRACY: I do.

2 CHAIRMAN BEARISON: Dr. Tracy, can you
3 answer his question just based on your
4 experience in doing what you do on a daily basis
5 down in the trenches?

6 I know I'm putting you on the spot, but I
7 think you can handle it.

8 DR. TRACY: I think attorney Nuland is an
9 attorney representing FAPM and there might have
10 been some cross --

11 DR. ROSE: But as a practicing condition --

12 DR. TRACY: Yes.

13 DR. ROSE: -- seeing a brand new patient --

14 DR. TRACY: Fifty minutes I spent with a
15 new patient.

16 DR. ROSE: How many?

17 DR. TRACY: 50.

18 DR. ROSE: 50. Five, zero.

19 CHAIRMAN BEARISON: With a new patient?

20 DR. TRACY: And that includes history --

21 DR. ROSE: That sounds a little more
22 realistic.

23 DR. TRACY: -- going over all the
24 documentation and imaging, patient -- discussion
25 with the patient, reading previous

1 consultations, examining the patient,
2 establishing a plan and discussing it with the
3 patient, the opioid agreement. I mean, 50
4 minutes and I think attorney Nuland really meant
5 to say that, but maybe 15 minutes with a
6 previously established patient.

7 And you know, that depends on the level of
8 service. A 99211 is different than a 99212 and
9 a 3. And that gets you into the physical exam
10 part because the level of service will put you
11 into how much of a physical exam you need to
12 provide to that patient.

13 A 99212 maybe you'd only need to do
14 reflexes and motor function and flexion and
15 extension and leg raise. 99213 would get you
16 into more of a physical exam than a 4.

17 So, sir?

18 CHAIRMAN BEARISON: So your answer then is
19 five zero for a new patient --

20 DR. TRACY: Five zero for a new patient.

21 CHAIRMAN BEARISON: Just based on your
22 experience. How long have you been doing this
23 for? Ten, fifteen years, twenty?

24 DR. TRACY: Twenty-two.

25 CHAIRMAN BEARISON: Okay.

1 DR. TRACY: I was fellowship trained in
2 pain management in 1988.

3 CHAIRMAN BEARISON: Okay. So I think that
4 information is real helpful. Now, I know I put
5 you on the spot, so now I'm going to let you go
6 ahead and take over and we'll listen to your
7 comments focused on this issue.

8 DR. TRACY: I also want to qualify that
9 statement with I do have a advanced registered
10 nurse practitioner and PA. So I'm able to see
11 more patients because they do some of the work.
12 But generally, for new patients I spend that
13 contact time.

14 I'm here as president of Florida's Society
15 of Interventional Pain Physicians, and just for
16 the public record, Mr. McPherson, not to insult
17 you, but in case the legislatures get to read
18 this comment period, we believe the intent of
19 the legislators was that these enormous amount
20 of pills going out the door in pill mills, tens
21 of thousands per patient. And I think that
22 there intent there was to limit that.

23 I don't think they intended to compromise
24 our care, but I think the majority of us as you
25 have heard feel that that is a probability here.

1 Especially Dr. Rosenberg's comment, I see myself
2 sitting in there trying to calculate on the 41st
3 patient how many I've written for the day and
4 possibly compromising the care that I could give
5 to that 41st patient.

6 So we do understand the intent of the
7 legislation and we do not feel it is fair for
8 this statute to impose the Board of Medicine to
9 create this number. That is for the public
10 comment.

11 In terms of the number of prescriptions,
12 yes, attorney Nuland is right. It's Schedule
13 II, Schedule III and Alprazolam. The problem
14 for me is seeing as how and many other of the
15 physicians have extenders, PAs and nurse
16 practitioners, how do you account for those
17 extra number of patients you're going to be
18 seeing.

19 So we feel that if the Board of Medicine
20 has to literally interpret this statute, that
21 the formula is the only way because different
22 clinics have different number of doctors,
23 different number of extenders. Some -- I have
24 two -- I am one solo practitioner with two
25 extenders.

1 We are aware of clinics that have five solo
2 practitioners -- or five physicians. We are
3 aware they have five plus three or four
4 extenders. So how do you do that? So I came up
5 with the word and if you read the letter
6 "provider."

7 So seeing as how you've already discussed
8 that a prescription can be written for a long
9 acting, a short acting and an anxiolytic, like
10 Alprazolam, that would be three prescriptions
11 for a patient. If you were to write a
12 do-not-fill for subsequent months, that could
13 potentially go up to six to nine prescriptions
14 for a patient.

15 So seeing as how some patients get no
16 prescriptions and some patients could
17 potentially get nine prescriptions, we came up
18 with the number similar to attorney Nuland's
19 suggestion of five per patient, per
20 practitioner, so that we would say per provider
21 150 or as I indicated here, if there were five
22 providers, it would be 750.

23 And in agreement with Dr. Cordner we would
24 rather see, and what Dr. Rosenberg pointed out,
25 we would rather see it be generous because we

1 believe that all the rules you are creating that
2 will take care of this in a global perspective.

3 Also I would like you to take into account
4 how you are going to audit these prescriptions.
5 If you are going to audit them on the day they
6 were written, then the representative for SFSFA
7 his comment about having a higher number on that
8 day would be necessary. If you're going to
9 audit them on the day they were filled by the
10 pharmacy, then that would change the number for
11 the day they were written.

12 I believe I've covered everything that I
13 wanted to say. Yes, sir?

14 MR. MCPHERSON: Doctor, roughly in a days
15 work, what percent of your pain management
16 clinics are new patients versus, you know,
17 established patients?

18 DR. TRACY: I see three to five new
19 patients a day and I see about fifty a day
20 sometimes more, sometimes less because I have
21 the ex-physician extenders.

22 MR. MCPHERSON: Okay. Three to five of the
23 patients you see would be new --

24 DR. TRACY: Per day.

25 MR. MCPHERSON: -- so the majority of the

1 patients you see are established?

2 DR. TRACY: Yes, sir.

3 MR. MCPHERSON: Okay.

4 CHAIRMAN BEARISON: It's probably in the 10
5 percent range.

6 MR. MCPHERSON: Do you know -- or do you
7 have a sense of whether or not that ratio is
8 consistent with other physicians that practice
9 in your area or are you out of sync with what
10 you think is going on in Florida as far as the
11 percent of new patients versus established?

12 DR. TRACY: I am not sure. I had this
13 discussion with Dr. Cordner, he lives in Vero
14 Beach, and he sees I think you said -- what was
15 that a day? Six to ten a day, new patients.

16 MR. MCPHERSON: Okay. So roughly 90
17 percent of your patients would be established
18 and that Dr. Cordner perhaps 80 percent would be
19 established?

20 DR. TRACY: I would say that's reasonable,
21 80 to 90 percent. Yes, sir.

22 MR. MCPHERSON: Okay. Thank you ma'am.

23 CHAIRMAN BEARISON: Any other Committee
24 members?

25 Dr. Rose?

1 DR. ROSE: You mentioned including
2 everybody, including physicians and providers
3 and during your calculations are you taking into
4 consideration the new legal requirements that
5 says the physician must do at least the
6 examination component on the day the
7 prescriptions are issued?

8 DR. TRACY: I have discussed that with my
9 extenders, and as I've already pointed out, my
10 level of service is usually about a two or three
11 for return patients. And I feel that I can get
12 in there and do reflexes, straight leg raise,
13 forward and a motor within just a few minutes.

14 DR. ROSE: Okay.

15 CHAIRMAN BEARISON: Thank you, Dr. Tracy.
16 Mr. McPherson.

17 MR. MCPHERSON: I don't think Ms. Conn has
18 a comment, but I do want to go through the cards
19 again.

20 Do you wish to speak on this issue?

21 MS. CONN: (Not using microphone.)

22 MR. MCPHERSON: Thank you.

23 Dr. Gerber, we have you down just for
24 accreditation, but --

25 UNIDENTIFIED SPEAKER: (Not using

1 microphone.)

2 MR. MCPHERSON: Oh, Dr. Gerber, please.

3 DR. GERBER: Quickly. I don't want to be
4 too repetitive. A lot of the points were
5 raised, but I've been doing this for 15 years
6 and I can tell you that there's very few pain
7 doctors doing this right that can see five
8 patients an hour for eight hours a day, forty
9 patients a day and write five scripts for
10 controlled substances and say they're doing it
11 right.

12 It takes 10 minutes just to walk in the
13 door, see how they're doing and come out and
14 write a script. That's assuming you're seeing
15 no new patients. I spend 45 minutes to an hour
16 with new patients. So if a doctor is seeing six
17 new patients a day, I don't see how he has any
18 time to do follow ups.

19 So my suggestion is we kind of come up with
20 the same formula. I say five patients an hour
21 for an eight hour day. That's 40 patients.
22 Three scripts for controlled substances per
23 patient not counting the post dated releases
24 which I do in my practice.

25 The pill mills are not doing that. That's

1 been raised. The pill mills are seeing people
2 every month, so this is not going to apply to
3 the pill mills. And also you're leaving out
4 another major drug in the holy trinity of
5 prescription abuse. It's the Roxy 30s, Soma and
6 Xanax. Nobody's even mentioned Soma here which
7 is probably the number two drug of prescription
8 abuse that we see in Florida.

9 So we're not even talking about Soma here,
10 so that's an extra one because your talking
11 about Schedule II and III and Xanax and Soma's a
12 Schedule IV. So that's a discussion for another
13 day.

14 So I'm saying three scripts per patient, 40
15 a day, 120 scripts for controlled substances per
16 provider because I also have a PA, so per
17 provider. And that means that you're seeing 40
18 patients every day. That's 200 patients a week.
19 That's 600 scripts for controlled substances not
20 counting the do not releases and the
21 do-not-fills.

22 I mean that is a hell of a lot of
23 prescriptions for controlled substances, and
24 that's implying that doctors are doing opioid
25 agreements, exams, urine screens. I mean, what

1 I just said isn't possible. I challenge any
2 physician to do that.

3 I see 20 to 25 patients a day, and I'm
4 exhausted at the end of the day doing that and
5 doing it right. And I have about 75 -- 70 to 75
6 percent of my practice is on controlled
7 substances. So not every patient is on a
8 controlled substance in a legitimate pain
9 practice.

10 There are patients on Ultram and muscle
11 relaxers and you know, anti-inflammatories, so
12 in the good practices not every single patient
13 is on a controlled substance and certainly not
14 five scripts.

15 So we need to come up with number like
16 Mr. Nuland raised somewhere between 120 and 200
17 a day is more than adequate. Because even at
18 that number, you're talking about very high
19 prescription writing. Because the pill mills
20 are seeing 50 patients a day, and they're
21 hustling the people in and out the door five to
22 ten minutes.

23 You can't see a new patient in 15 minutes
24 under this new law. It's impossible. It's
25 impossible. You -- maybe a half hour at best

1 and that's quick. To do a urine screen and
2 counsel them and do an exam and look at the
3 chart, look at the MRIs, examine the patients.
4 I mean, half hour goes by real quick.

5 So we're talking about high numbers. So my
6 suggestion is 120 to 200 per provider and you
7 guys can come up with some number in between
8 there. And I would make it say don't include
9 the do-not-releases because we all have patients
10 that we see for the second and third month.
11 Because if you start to include that in there,
12 you're really going to come up with all kinds of
13 wacky numbers per practice. So limit it to
14 those patients you're seeing that day.

15 Thank you.

16 CHAIRMAN BEARISON: Thank you, sir. You
17 can stay here in case you have questions.

18 Dr. Winchester?

19 DR. WINCHESTER: You know, we've had quite
20 a bit of -- and I'm sure we'll have more
21 discussion on numbers, but I'm just thinking
22 that five sure seems excessive. It's hard for
23 me to imagine five different prescriptions for a
24 Schedule II or Schedule III drug. That just
25 seems like an awful lot.

1 And the Alprazolam that's really a
2 non-issue because they're going to use some
3 other benzodiazepine so it doesn't really --
4 Alprazolam doesn't really count. Just in my
5 mind listening to the testimony, I'm thinking
6 more in the three to four range per day.

7 CHAIRMAN BEARISON: Dr. Rosenberg.

8 DR. ROSENBERG: Doctor, how many patients
9 do you personally see per day?

10 DR. GERBER: I do also procedures some
11 days. I'm in the operating room --

12 DR. ROSENBERG: If you're not doing
13 procedures, what would it come out to?

14 DR. GERBER: Myself, 20 to 25. I mean, I
15 don't ever remember a day where I saw more than
16 25. I schedule about four follow-ups an hour
17 and if I have a new patient thrown in there,
18 it's 45 minutes for a new patient.

19 DR. ROSENBERG: And the PA sees how many?

20 DR. GERBER: Never more than 20.

21 DR. ROSENBERG: So we're still talking
22 around 40?

23 DR. GERBER: You know, some doctors may see
24 more. I mean, you know 50. I think 30 patients
25 per provider is about an average of what people

1 are realistically --

2 DR. ROSENBERG: But the PA can't prescribe
3 narcotics, so you're still seeing those
4 patients?

5 DR. GERBER: Well, I have to -- I eyeball
6 the patients, I see them. I co-sign the script.
7 I see how they're doing, but I don't physically
8 -- well, right now before this new law, I mean,
9 I don't physically do an exam. I mean, that's
10 the whole purpose.

11 I mean, I can tell you what we discuss here
12 and what really happens in the real world are
13 going to be two different things because there
14 is no doctor that is doing a physical exam on
15 every patient that the PA and the nurse
16 practitioners see. It's an impossibility, and
17 this has been discussed at prior meetings.

18 We have mid-level providers which the Board
19 of Medicine supports. The legislature is coming
20 up with a different set of guidelines. I mean,
21 we as clinicians -- I mean, we might as well
22 fire all of our nurse practitioners and PAs if
23 we have to go in the room and do a physical exam
24 on every patient that's on an opioid.

25 I mean, this is going to be an issue that's

1 going to be discussed for years to come. I
2 don't know around that, but I'm going to have to
3 go in now and check a straight leg raise and
4 say, yeah, I did an exam. I mean, it's a
5 ridiculous legislative law because nurse
6 practitioners and PAs are hired so we can depend
7 on them to evaluate patients. But I sign the
8 scripts, I mean, I sign the scripts when they
9 come out.

10 DR. ROSENBERG: Looking at the absolute
11 number, the concern I have with basing it just
12 on providers is the physician that is not as
13 reputable as you. We'll go out and hire four or
14 five PAs just so that they can quadruple the
15 number of prescriptions. And obviously can be
16 lucrative enough to justify doing that. That's
17 my concern with basing it on providers rather
18 than just physicians.

19 DR. GERBER: Well, that's how you can limit
20 the number of maybe patients seen per provider.
21 I think five follow-ups an hour per provider is
22 reasonable. I mean, first of all when the
23 department -- you know, we have to answer the
24 law to the legislative. The legislative wants
25 -- they want an answer, so we give them a

1 number. But that's going to have nothing to do
2 when the department comes in and inspects the
3 practice.

4 I mean, if you've got five physician
5 extenders and there's 35 people sitting in the
6 waiting room and all you see coming out the door
7 is Soma, Xanax and Oxycodone, our investigators
8 are going to pick up on that and their charts
9 are going to be reviewed.

10 We just have to answer one question to
11 satisfy the legislature, so we can come up with
12 whatever number we want. But it's not going to
13 supercede the way we practice and uphold the
14 rest of the legislative law and the rest of the
15 pain clinic registration.

16 That's way more important than coming up
17 with this absolute number. This absolute number
18 is just -- it's really just a moot point. It's
19 smoke and mirrors against the rest of a good
20 bill. So we just have to come up with some
21 number so that, you know, it's just reasonable
22 and not excessive.

23 So somewhere between 120 to 200 scripts per
24 provider is reasonable. I mean, the pill mills
25 are way beyond that already, so if they want to

1 go out and hire six PAs per doctor, and the
2 inspector comes in and they see, you know, that
3 the place is out of control, well, they're just
4 going to pull a couple of charts and see how
5 they're doing it.

6 Because, again, unless you're doing it
7 right, you know, the records are going to speak
8 for themselves. Everything goes down when I
9 give lectures, it's documentation,
10 documentation, documentation and we're going to
11 pick that up when inspectors go in there.

12 CHAIRMAN BEARISON: Okay. Thank you very
13 much, sir.

14 DR. GERBER: And I think the --

15 CHAIRMAN BEARISON: You can go ahead and
16 sit down. One important thing, again, is that
17 this just one piece of it, don't forget. Just
18 the number of prescriptions. Everything else is
19 also involved in this too. So it's just not --
20 I don't want everybody to just get hung up on
21 the number of prescriptions when we have all
22 these other things in place too.

23 Doctor -- Mr. McPherson, I'm sorry. We'll
24 make you a doctor yet. Don't worry.

25 MR. MCPHERSON: The next Mr. Terranova.

1 You were here for accreditation. I'm assuming
2 you don't really have a comment here. Thank
3 you.

4 Same with Ms. Hoppe. You were here for
5 accreditation. I don't think you have a
6 comment, do you on this? Thank you.

7 Next is Mr. Sloan. Mr. Sloan also
8 addresses, I think, what Dr. Winchester brought
9 up about some of the impact of Federal
10 legislation. If you look at Tab 19 of Book 2, I
11 think you'll see some information on Federal
12 requirements.

13 CHAIRMAN BEARISON: Sir.

14 MR. SLOAN: Well, according to the FSA on
15 the illegitimate pain clinic, but let's pretend
16 for a moment that I'm not. I'm sort of amazed
17 the numbers I'm hearing here. I guess I'm doing
18 something wrong, but again, I'm not a doctor.
19 I'm not a clinician.

20 But I don't think my doctors have ever seen
21 more than 30 patients in a day. On average I
22 think we see about 25 per doctor. We schedule
23 at 15 minute blocks for a follow up patient. We
24 schedule at an hour and a half for a new
25 patient.

1 I probably -- my clinics probably on an
2 average see 4 new patients a week. By the time
3 the 100 phone calls get whittled down to two
4 legitimate patients, that's who we actually see.
5 So I guess I'm doing something wrong and could
6 probably double my revenue if I go to 50
7 patients a day, but I think I'd kill my doctors.

8 We have no extenders. We have no PAs, no
9 nurse practitioners. My patients see a doctor
10 every visit, every time. I don't know anybody
11 that's leaving with five scripts, but I don't
12 disagree with Deborah Tracy who's the president
13 of FSIPP about her request for five scripts, but
14 I don't think that should be the ultimate
15 standard because then you're just setting this
16 huge number.

17 The Florida Medicaid through US Medicaid
18 set -- in August, set a standard for C threes
19 and fours of no more than four scripts. And any
20 additional scripts would have to be prior
21 authorized. My recommendation to the Board is
22 that you use -- slightly modify that and use C
23 II, C III and Alprazolam no more than four
24 scripts. Anything additional would have to be
25 put in the chart like you were going for prior

1 authorization.

2 And anybody who inspects the chart would
3 see that the fifth script was highly documented
4 as an abnormal in terms of before that you're
5 exceeding. I mean, if you have to do it for
6 Medicaid, you might as well do it for your
7 chart.

8 The issue here is that -- and one thing I
9 read is I read these prosecutorial service
10 probably cause. I spend a lot of time reading
11 them, and the average patient -- and you'll see
12 in these reports that are written by these board
13 certified docs, is that one of the biggest
14 complaints is these patients are not on both a
15 short term and a long term.

16 So, again, I'm not a doctor. I'm not
17 practicing medicine and so please don't think
18 that I am. But in three and a half years what
19 I've come to learn is that if a patient is on
20 two C II, both on the long term and the short
21 term whether it's OxyContin and oxycodone as a
22 breakthrough or Dilaudid as a breakthrough,
23 there you have two C IIs on a chronic pain
24 patient in case of something like Lyrica, but
25 that's a C IV. I believe it's not even a C III,

1 but you may be even using something like
2 hydrocodone base product which would be a C III.
3 And then you have your Xanax.

4 And not every patient leaves with a Xanax,
5 but I would say my average patient -- or my
6 doctor's average patient to be correct, is
7 leaving with three scripts. That would be
8 average.

9 A lot of them are only leaving with two.
10 Some are only on one, but I don't think I have a
11 patient or the doctors have a patient that leave
12 with five scripts. It's a very unusual case,
13 but there are a couple, I think there are a few
14 that are on significant medications and
15 different types.

16 So if you use the Florida Medicaid rule,
17 and you do the four scripts per doctor per 30
18 days. You know, one of these things is a lot of
19 these clinics are doing 21 day visits. Some
20 people will object to what I say, but I think
21 the 21 day is a huge revenue generator.

22 Right here you're immediately eliminating
23 this 21 day thing which actually what they do is
24 it generates three extra visits a year which is
25 \$300 and plus the scripts and all that. So

1 right here this rule immediately eliminates
2 because it's a 30 day rule. So you eliminate
3 that 21 day cycle right off the bat which takes
4 a huge chunk out of these pill mills revenues.

5 Some of them will say they have legitimate
6 reasons for doing it. I never understood it,
7 but -- so if you use what my formula was and you
8 say, again, some of these doctors are seeing 40
9 patients a day in board certified offices. I
10 can't argue with that.

11 But if you use the four as your number,
12 just like Florida Medicaid says, and in this
13 case it's including twos where they were just
14 using threes and fours, you would find a good
15 standard that's already existing and is not
16 arbitrary and capricious. And you base it on
17 the number of doctors.

18 And I don't understand the 24 hours. I
19 mean, a clinic -- and we open at 9:00 and we
20 close at 5. My doctors are generally gone
21 earlier, but again, we don't schedule more than
22 four 15 minute follow-ups and the doctor sees
23 everyone of those patients.

24 So the idea of -- I don't know about 700,
25 but because I think you're just opening up a can

1 of worms there that everybody's going to think
2 -- but if you do the four script formula which I
3 detailed in my letter based on the Medicaid,
4 that would give you the best number.

5 I think there has to be one other exception
6 that somehow you have to put in this is every
7 once in a while my doctors -- I'll have two
8 doctors working on any given day and one doctor
9 is delayed in a car accident, whatever, I mean,
10 calls in sick, and I have to double those
11 patients up. And that's a very rare case. But
12 you have to take into consideration things
13 happen.

14 CHAIRMAN BEARISON: Thank you, Mr. Sloan.
15 Dr. Tucker.

16 DR. TUCKER: I guess I'm hearing some good
17 information from everybody, but I would like to
18 ask Mr. Tellechea does the statutes say for the
19 entire -- to number the amount of prescriptions
20 or the maximum amount of prescriptions that can
21 be written in a 24 hour period per clinic or per
22 doctor?

23 MR. TELLECHEA: Clinic.

24 DR. TUCKER: Per clinic.

25 MR. TELLECHEA: Yes, ma'am.

1 DR. TUCKER: Okay. So I don't see how --
2 we can make a very simple formula, but what I
3 don't -- I may be a little premature in saying
4 this without hearing the rest of the speakers,
5 but this -- the three, four and five is what
6 I've been hearing. So if you take the average
7 of between 25 and 50 patients, you come up with
8 roughly 40. Three prescriptions per patient,
9 that's 120 per doctor.

10 Now, one patient may -- not including the
11 ones that are do-not-fill, but one patient may
12 walk out with five and another patient may walk
13 out with one. So if we had a limit of 120 per
14 doctor that makes it pretty easy. You don't
15 have to do per patient per day, but per doctor
16 then that makes it easy for the inspectors to
17 come in and see how many prescriptions were
18 written on Friday and how many doctors did you
19 have here that day and multiply it by 120.

20 But I'm hearing 40, 50, 30, 25. Four
21 prescriptions, three prescriptions, so I just
22 kind of hit it in the middle and 40 patients
23 with three prescriptions, that's 120. That's
24 just a suggestion.

25 MR. SLOAN: One thing you have to be

1 careful here is making it easy for the
2 inspectors and also providing the proper care
3 and not limiting the doctor. You just have to
4 give them the ability -- and I think it's just
5 real key that you -- no matter what you have to
6 have some availability or ability to take in the
7 exception. And again --

8 DR. TUCKER: Well, that's why I said --
9 because one patient may walk out with one, one
10 may walk out with five. So if you say 120 for
11 the doctor to write, then you can take into
12 account those exceptions because I would venture
13 to say I haven't heard anybody here say that
14 every patient walks out of their office with
15 five prescriptions or four prescriptions or
16 three.

17 MR. SLOAN: No --

18 DR. TUCKER: You can't say that. That's
19 why I came up with --

20 MR. SLOAN: I agree.

21 DR. TUCKER: -- the number average of
22 number of patients seen by the average number of
23 prescriptions.

24 MR. SLOAN: Again, one of the biggest
25 concerns is if I have an a doctor can't make it

1 to work and you have all these patients and
2 these are patients that are on a cycle where not
3 having their meds there has to be some ability
4 to have an exception where a doctor -- one of
5 your doctors doesn't come in and you have to
6 double up your patients.

7 This happens whether it's in my clinic or a
8 board certified clinic or in any type of
9 practice where you have to deal with these kinds
10 of emergencies, so let alone natural disasters
11 things like that.

12 CHAIRMAN BEARISON: Okay. Thank you for
13 bringing that to our attention. Dr. Burns you
14 had a comment.

15 VICE-CHAIR BURNS: Yes. I really
16 appreciate Dr. Tucker's comments and I recognize
17 Mr. Sloan's concerns about exceptions. One
18 thing we also want to be careful of is the
19 opposite exception where you may have a facility
20 that a physician only works one hour or half of
21 a day and how that changes the numbers when you
22 look at it per physician.

23 Thank you.

24 CHAIRMAN BEARISON: Mr. McPherson.

25 MR. MCPHERSON: Dr. Creamer.

1 THE REPORTER: Do you swear or affirm the
2 testimony you give here today will be the truth,
3 the whole truth and nothing but the truth?

4 DR. CREAMER: I do.

5 THE REPORTER: Thank you.

6 DR. CREAMER: Dr. Michael Creamer. I'm a
7 specialist in physical medicine and
8 rehabilitation, subspecialty certified in pain
9 management, pain medicine. And I represent the
10 Florida Society of Physical Medicine and
11 Rehabilitation.

12 Just some additional comments. My overall
13 view is very similar to Dr. Gerber, Dr. Tracy.
14 I hope that the Board, through their rules, can
15 try to keep this rule rather simple and
16 generous. I personally feel that this is
17 inappropriate and I think it puts undo
18 restrictions on physicians.

19 Having said that I also agree with Dr.
20 Bearison in that the rules that are already
21 established I think should be very effective for
22 those individuals performing inspections and
23 having access to these clinics to be able to
24 assist in putting pill mills out of business.
25 So I think that we need to be fairly generous in

1 rules that are made in this regard.

2 I also have nurse practitioners, physician
3 assistants and so I would hope that any rule
4 that relates to the number of prescriptions in a
5 pain clinic per day would also utilize the term
6 provider because that certainly would have a
7 significant change in the amount of numbers that
8 would be generated as far as prescriptions.

9 I also agree with the statement of one
10 prescription would incorporate additional
11 prescriptions that would be predated as
12 Dr. Winchester had stated.

13 I don't necessarily see that there should
14 be an issue incorporating some rule that states
15 new patients would have a higher or lesser
16 degree of prescriptions as compared to
17 established patients either. I think that
18 certainly can be incorporated into one rule.

19 I agree with the four prescriptions per
20 patient per provider. I think that would seem
21 to be a reasonable amount of prescriptions per
22 patient. And one has to obviously consider the
23 use of long acting, short acting, and other
24 types of medications that are utilized to treat
25 pain in trying to address the various components

1 and the pain generators and how best we can
2 treat these patients.

3 I struggle with the limit per clinic being
4 relatively inappropriate and I think that really
5 has to be a formula that incorporates a per
6 provider, per patient and allows some
7 flexibility to incorporate the use of physician
8 extenders. And I certainly see that this is an
9 area that will continue to expand as the years
10 progress in the State of Florida as the
11 population increases, the number of physicians.

12 The physicians are not able to keep. There
13 are certainly a lot of restrictions that are now
14 being placed on physicians to want to become
15 pain management physicians, run pain management
16 clinics. There's going to be a need to have a
17 further emphasis on the use of physician
18 extenders in maintaining the ability to practice
19 and help patients.

20 Our nurse practitioners do an excellent job
21 in helping to maintain patients who are on
22 routine medications. It also enables us to be
23 able to pursue interventional procedures and
24 implantable devices to help with pain.

25 So again, we have to take into

1 consideration the need for providers as the
2 years progress over time.

3 I believe I've covered most of the point
4 that --

5 VICE-CHAIR BURNS: Once again, this is a
6 reminder that we're trying to focus just on what
7 we have rule making authority on. We have to
8 comply with the statutory requests from the
9 legislature.

10 At this time any comments or questions from
11 Board members?

12 Dr. Winchester?

13 DR. WINCHESTER: Doctor, I'm still trying
14 to understand about the four and five
15 prescriptions, that would be Class II and Class
16 III. So can you give me an example of a common
17 example of someone getting four Class II or
18 Class III prescriptions at a time? What
19 medications?

20 DR. CREAMER: I tried to think about that
21 myself and I couldn't come up with it. I guess
22 my own personal feeling is trying to be fairly
23 flexible in incorporating a total number. I
24 mean, I would say that the vast majority of
25 patients we're going to prescribe a long acting

1 and short acting for the vast majority.

2 And that's it. And that's typically what
3 we see in addition to neuroleptic medication
4 such as Lyrica and Neurontin, anti-depressant
5 medications, but they don't incorporate into
6 that rule. So, you know, two as established --
7 recommended by the Florida Society of
8 Anesthesiology seems very reasonable.

9 There may be a situation where four may be
10 appropriate, but I just have a hard -- it's hard
11 for me to grasp the thought of the legislature
12 trying to restrict physicians in regards to
13 their practice.

14 DR. WINCHESTER: Well, that part -- that's
15 a separate issue, but I really, again, have a
16 hard time figuring out how an average person
17 which would be -- because we're talking about
18 averages, would be given four Class II or Class
19 III prescriptions. I just can't imagine that.
20 Certainly the two would be very, very common.
21 So the more I hear about this, the more I'm
22 thinking three is a better number for those
23 Class II and Class III and again the Alprazolam
24 doesn't count.

25 DR. CREAMER: Thank you.

1 CHAIRMAN BEARISON: Dr. Rosenberg, do you
2 have anything? And then Dr. Rose.

3 DR. ROSENBERG: I was just going to suggest
4 an option for that rule, but I can wait until
5 other people go.

6 CHAIRMAN BEARISON: Yeah, let's go through
7 all the speakers and then we can kind of go
8 through that.

9 Dr. Rose, any questions?

10 DR. ROSE: I just had a question again in
11 dealing -- thinking about the issue between
12 physician and provider now that we have the new
13 requirement that they physicians examine the
14 patient on the day, at least do the physical
15 examination on the day the prescription is
16 issued.

17 It just doesn't seem that the same number
18 of prescription per either physician or provider
19 should be the same. It seems like the number
20 prescriptions maybe would be less for the
21 physician extender than it would be for the
22 physicians.

23 Since the physicians going to have to come
24 in and do now at least a physical exam component
25 on there, so how do you rationalize that as

1 being the exact same number per provider when
2 you should say -- if you say it's four per
3 provider?

4 How is that the same and now you've got to
5 come in and do some of their work? And now
6 you're seeing the patient and you're actually
7 the one issuing the prescription because it's in
8 your name. So how are you counting as many
9 prescriptions that they can write that you're
10 doing?

11 DR. CREAMER: Well, I think a lot of it has
12 to do with time savings that a physician
13 extender, nurse practitioner provides to a
14 physician. Accumulating all the data, looking
15 over records from referring physicians, making
16 phone calls to referring physicians, making
17 phone calls to the pharmacies.

18 Some of the patients that we experienced
19 this week, we had to call a pharmacy to verify
20 prescription records. We had to call a
21 physician office to verify that the patient has
22 received certain medications. So what the
23 providers assist us in is reducing time and
24 helping to allow us to be able to make a better
25 clinical decision.

1 DR. ROSE: How would you estimate that time
2 if you did it totally yourself 100 percent, if
3 you had them step in, what percent of that 100
4 is the part that you do and what percent would
5 they do? 75, 25 or what? Just a rough estimate
6 that they're able to do for you in gathering all
7 that information.

8 DR. CREAMER: I would say gathering --
9 probably about 80 percent of what we do when
10 we're looking at patients is gathering
11 information. The clinical examination is
12 relatively straight forward. You're listening
13 to heart, lungs, abdomen, examining their
14 extremities, checking reflexes.

15 The biggest part in these types of patients
16 are gathering the history. Where do they come
17 from? Where's the medications? You know,
18 reviewing urinalysis results. Having another
19 extender be able to pull that all together and
20 then present it in a concise format is very
21 essential to quality of care and helps -- allows
22 us to improve patient care to these patients as
23 well as being able to address the needs of other
24 patients which there certainly is a great need
25 for physicians in this community and in Florida

1 and the State to provide adequate pain
2 management, you know, procedures as well as
3 general care.

4 So that's really where it comes in to.
5 It's pulling it all together for us so when we
6 enter into a room, we're not having to search
7 for all this. We can go right to the point and
8 have it put together in a format that's very
9 concise and helpful for us and for the patients
10 too.

11 DR. ROSENBERG: Okay. I think that
12 incorporating the physician extenders in the
13 calculations is only critical if we're going to
14 come up with an absolute number of prescriptions
15 per day. If we use a formula that's based on
16 number of prescriptions per patient per
17 physician, all of those patients are see by
18 physician extenders are still technically the
19 physician's patient.

20 And it gives us the flexibility to come up
21 with -- personally I think a more appropriate
22 formula. If we come up with an arbitrary number
23 then we do have to anticipate the role of
24 physician extenders and number physician
25 extenders et cetera, et cetera. The number of

1 follow-up visits, new visits, just way too
2 complicated and inappropriate in my mind.

3 VICE-CHAIR BURNS: I support

4 Dr. Rosenberg's comments.

5 CHAIRMAN BEARISON: Mr. McPherson.

6 MR. MCPHERSON: Thank you.

7 CHAIRMAN BEARISON: Thank you, sir.

8 MR. MCPHERSON: Is it Dr. Albert Ray or
9 Mr. Albert Ray?

10 DR. RAY: (Not using microphone.)

11 MR. MCPHERSON: Dr. Ray?

12 THE REPORTER: Do you swear or affirm that
13 the testimony you give here today will be the
14 truth, the whole truth and nothing but the
15 truth?

16 DR. RAY: (Not using microphone.)

17 THE REPORTER: Thank you.

18 DR. RAY: Good morning. My name is Bert
19 Ray.

20 You were asking before for a clinician.
21 I've been practicing pain medicine for 37 years.
22 I have interdisciplinary pain program in Miami.
23 I'm board certified in pain management. I'm
24 board certified in psychiatry. I've been the
25 president of the American Academy of Pain

1 Medicine. The president of the Southern Pain
2 Society.

3 I've been a director on the American Board
4 of Pain Medicine. I'm still on their exam
5 counsel. I'm also president of the Foundation
6 for Pain Medicine. I also represent the Florida
7 Academy of Pain Medicine here. I'm a member of
8 their board of directors as well.

9 When we were trying to come up with a
10 formula that would help address the issue that
11 the legislature wants addressed and at the same
12 time take a look at what is the issue that we're
13 dealing with, the intent of the law is to try
14 and shut down the pill mills without interfering
15 with legitimate pain practice as best possible.

16 So the formula we came up with we tried to
17 look at -- we surveyed ourselves, and we agree
18 with what some of the other speakers said. Most
19 of us see a maximum -- if we're just going to do
20 nothing but medication checks that day, most of
21 us would see a maximum of 20 to 25 patients. So
22 we tried to be generous and say, okay, maybe
23 somebody could see 30. It depends on how many
24 hours a day you want to work.

25 The pill mills, however, are making their

1 money on volume. So I think we need to be very
2 careful, and the reason we set a limit of 30
3 patients per doctor or 30 -- between 30 and 40
4 per doctor as an upward limit of what you can do
5 legitimate pain medicine.

6 My own practice I have leisure of a two
7 hour initial evaluation. That's the longest
8 I've ever heard. It's my own choice, so I have
9 that pleasure. If you look at the VA system or
10 you look at Mayo Clinic they allow 30 minutes
11 for a new patient. So that's a relatively short
12 time. Dr. Tracy was 50 minutes. So I think
13 somewhere between 30 minutes and two hours is
14 where you're going to find somebody needs to see
15 a complex pain patient from start to finish.

16 Medication follow-ups I do in 15 minutes.
17 So the follow-ups can be shorter. Once somebody
18 is established in terms of what they're going to
19 do just for their medications. The rest of my
20 treatment program is a very intense program, so
21 we're low volume, high intensity.

22 We have people there four to five hours a
23 day sometimes through various therapies. So
24 we're only treating maybe 10 patients at a time.
25 It's a low-volume practice. So the numbers that

1 we're hearing -- and Dr. Tucker came up with
2 125.

3 I think if you look at the problem with the
4 physician extenders is that's how the pill mills
5 make their money. So they'll high one or two
6 physicians and by law they can have three nurse
7 practitioners per physicians, okay. That's now
8 six practitioners. And if you allow six
9 practitioners to write 50 prescriptions a day
10 each, then you're up to 300 prescriptions from
11 that clinic.

12 That's not quality pain medicine. Even
13 Dr. Tracy with her extenders is still talking
14 about 50 patients a day tops. And I think when
15 you're looking at numbers, we're trying to be
16 reasonable in terms of being flexible for
17 legitimate patients, but if you don't put some
18 limit on it that's going to address the volume
19 issue and you allow any physician to hire all
20 the extenders they want and use them to see the
21 name number of patients that they're seeing,
22 then you will not be able to put a dent into the
23 pill mills because you're not going to touch
24 their volume.

25 So the Academy when we came up with five

1 prescriptions, we were looking at five
2 prescriptions for controlled substances. If we
3 narrow that down to just the C IIs, IIIs and
4 Xanax, we would be very comfortable with a
5 maximum of three per physician.

6 The other question that comes up is how are
7 you going to monitor this? If this is going to
8 monitored through the database from prescription
9 monitoring system, then it doesn't matter how
10 many extenders you have, all of those
11 prescriptions will be under the physicians name.
12 And so whatever limit you put -- if you put a
13 limit per physician, then you're going to have a
14 better since of how many are actually coming out
15 of that clinic per doctor per day.

16 And we also recommended that that it be an
17 average to accommodate that flexibility that
18 people have spoken about.

19 Thank you.

20 CHAIRMAN BEARISON: Thank you very much,
21 sir. That was very, very enlightening, very
22 helpful.

23 Mr. McPherson, let's finish up with the
24 comments then the Board can go from there.

25 MR. MCPHERSON: I had a card from

1 Dr. Rivenbark. If there are any questions, is
2 there anything that you wanted to say

3 Dr. Rivenbark.

4 DR. RIVENBARK: No.

5 MR. MCPHERSON: Also had a card from Anna
6 Small. Is there anything you wanted to address?

7 MS. SMALL: (Not using microphone.)

8 MR. MCPHERSON: Thank you. Mr. Chair and
9 members of the Board that concludes the speakers
10 on this second issue, the 24-hour limit.

11 CHAIRMAN BEARISON: Do we want to take a
12 break and then come back and finish up? I think
13 some people need to check out.

14 What's the feeling of Committee members?

15 Did you want to have a lunch break? Take a
16 half an hour or what's your feeling? Half hour,
17 45 minutes, whatever you all want to do.

18 Somebody help me.

19 DR. TUCKER: Well, if we're going to take
20 -- checkout and take lunch just because it's the
21 lunch hour, I'd say an hour.

22 CHAIRMAN BEARISON: Mr. McPherson, how much
23 more do we have to do, do you think?

24 MR. MCPHERSON: Well, is that going to put
25 a dent in anybody? Is there anything that

1 someone needs to say? Will everybody be able to
2 be back here in an hour?

3 CHAIRMAN BEARISON: It's 12:10. How about
4 1:00?

5 MR. MCPHERSON: Yeah.

6 CHAIRMAN BEARISON: And hopefully we can
7 tentatively plan to finish before 3:00. Does
8 that sound reasonable?

9 Yeah. I think if we plan to come back at
10 1:00 we definitely should be able to get done by
11 3:00, and I think -- would that fit with
12 everybody's schedule?

13 Okay. Well, let's break now and we'll get
14 back at 1:00 and tentatively plan no later than
15 3:00 then.

16 Thank you.

17 (A lunch break was had.)

18 CHAIRMAN BEARISON: Let's go ahead and get
19 started. Dr. Steven Rosenberg had an
20 announcement.

21 DR. ROSENBERG: If anybody likes star
22 fruit, my tree has thousands on. There's two
23 bags there, please take as many home with you as
24 you want. If you've never had star fruit,
25 definitely take some give it a try. But I don't

1 want to take them home.

2 CHAIRMAN BEARISON: Thank you. Next,
3 before I forget, I need a motion to approve the
4 minutes of our prior meeting.

5 VICE-CHAIR BURNS: So moved.

6 DR. TUCKER: Second.

7 CHAIRMAN BEARISON: All in favor?

8 (Committee members responded.)

9 Opposed? (No response.)

10 Okay. They're approved.

11 Next, Dr. Winchester has his hand up. Sir?

12 DR. WINCHESTER: I'd like to make a motion,
13 and this motion is based on oral evidence,
14 written evidence. Also, drawing on my 30 years
15 of experience as a primary care physician and
16 thinking of what's possible and what's not
17 possible in a day's work.

18 The assumptions I'm using is for the
19 physician seeing 30 patients and one extender
20 seeing 20 patients, that would be 50 and with
21 the new laws and rules, that quite frankly will
22 be a number that may be onerous on a physician
23 to do considering the requirements placed on
24 physicians at this point. And I would make the
25 assumption of three prescriptions per patient

1 which I think is possibly overly generous.

2 So my motion would be that we set up a
3 formula based on 150 prescriptions per physician
4 per 24 hours.

5 CHAIRMAN BEARISON: Is there a second? And
6 then discussion.

7 DR. TUCKER: Second.

8 CHAIRMAN BEARISON: And discussion.

9 Dr. Tucker?

10 DR. TUCKER: What -- someone made the point
11 when we broke for lunch, a member of the
12 audience saying, "well, some of these people
13 will write a prescription not just for a month,
14 but they're write it for like 180 pills or
15 something like that."

16 Is there any way we could craft it to say
17 150 monthly prescriptions, but we consider --
18 for the purposes of this rule, we consider do
19 not refill until prescriptions as one
20 prescription?

21 DR. WINCHESTER: Yes. I'm very much amiss
22 at not putting that in my motion.

23 The do-not-fill does not count, and I think
24 it would be fine to say these are 150 monthly
25 prescriptions.

1 DR. TUCKER: Okay.

2 CHAIRMAN BEARISON: Dr. Rosenberg?

3 DR. ROSENBERG: Well, I agree with the
4 formula as long as it represents that number of
5 patients, but as has been pointed out earlier,
6 if a doctor sees one patient then writes 150 for
7 that one particular patient then that's not the
8 intent.

9 So I'm tempted to offer an alternative
10 where we use an average per day, per doctor, per
11 patient of three such controlled substances
12 which would come out basically the same,
13 assuming that's what the number of patients are.

14 But it gives some flexibility to a doctor
15 who might be seeing more patients for whatever
16 reason, and yet it also doesn't allow a
17 physician to over prescribe if they're only
18 seeing five or six patients that day.

19 So that would be an alternative formula
20 that I would be more comfortable with.

21 CHAIRMAN BEARISON: Mr. Tellechea?

22 MR. TELLECHEA: Well, as I had mentioned
23 earlier today, probably one of the disclaimers
24 that you want to have in this rule is saying
25 that this limit on number of prescriptions, you

1 know, per pain clinic does not supercede the
2 standard of care as to the appropriate numbers
3 of, you know, drugs that should be prescribed to
4 a patient given the particular facts and
5 circumstances of that case.

6 So I think that would cover that, that
7 issue. So if you have the one patient and the
8 one patient gets 150 prescriptions, you know,
9 the standard of care -- you're going to get that
10 person anyway for violating the standard of care
11 for over prescribing on a (q) violation. So
12 that might take care of your issue if you're
13 concerned with that.

14 I would use that disclaimer language also
15 about the standard of care, nonetheless, on this
16 rule.

17 CHAIRMAN BEARISON: Any further discussion?
18 Dr. Burns?

19 VICE-CHAIR BURNS: How do we address the
20 concern of a physician only works one or two
21 hours in a clinic in any given day?

22 DR. WINCHESTER: I don't see any way you
23 can. By the same token, you're going to have
24 some physicians who will be working 12 hours.

25 You know, the one hour a day and they get

1 150 prescriptions, the issue would be covered I
2 think from the comments that Ed just made.

3 VICE-CHAIR BURNS: I'm just wondering if
4 you had a physician that drove around to three
5 or four different clinics and worked an hour
6 each one in order to just get that quota up for
7 that facility.

8 DR. WINCHESTER: You know I am sure that
9 there's going to be some people that are going
10 to figure out someway around whatever we do.
11 And I don't think it's possible to have it
12 ironclad.

13 DR. ROSE: Can you put language in there
14 like all the Federal regulations do that if any
15 attempt or manipulation to circumvent this rule
16 is also a violation if people are trying to pull
17 little tricks or things? The feds do that a lot
18 and stuff with the anti-kickbacks, Stark laws
19 and statutes.

20 If a doctor sets up some scheme that they
21 think is outside the law, because technically
22 it's not the same, but that's a violation if
23 you're just trying to find a way around the
24 rule.

25 MR. TELLECHEA: Well, I mean, all those

1 provisions are still in effect. So if they're
2 trying to find a way around that rule that
3 violates one of the other provisions, then
4 you're going to get them on violating another --
5 you don't have to put in the rule that all the
6 others, you know, things that are precluded by
7 law are also -- it's just -- it stands as it is.

8 CHAIRMAN BEARISON: Ma'am?

9 MS. MCNULTY: Thank you. What about -- and
10 this is just for discussion -- the concept of
11 kind of trying -- it might be too confusing, but
12 maybe we could work on the language if you're so
13 inclined -- to do a formula suggested like
14 average per day, you know, by doctor, by
15 patient, not to exceed 150 scripts per day. So
16 you kind of put a cap in place, but you have a
17 formula.

18 DR. WINCHESTER: Sure. That's fine.

19 (CROSSTALK.)

20 DR. ROSE: That would fix that.

21 DR. TUCKER: I'm sorry. Can you repeat
22 that?

23 MS. MCNULTY: So in other words you put
24 your formula of -- that has been suggested. The
25 average per day, say three scripts, by the

1 number of patients, whatever you suggest your
2 formula is, not to exceed 150 per day, so that
3 there's a strict cap on the number of
4 prescriptions, but it would -- if you had a
5 formula, it would also capture those physicians
6 who might only be working three hours.

7 MS. GOERSCH: Right.

8 MR. TELLECHEA: We could try that. I think
9 JAPC may have an issue with that, but I think we
10 can definitely try it.

11 CHAIRMAN BEARISON: Do you want to kind of
12 rework your motion then, Doctor?

13 DR. WINCHESTER: The motion is to allow an
14 assumption of 50 patients per day per physician
15 at three prescriptions not to exceed 150
16 prescriptions per day. The prescriptions in
17 this count do not include the do-not-fill
18 prescriptions.

19 DR. TUCKER: Monthly.

20 DR. WINCHESTER: And these are monthly
21 prescriptions, that's right.

22 CHAIRMAN BEARISON: So that includes the
23 Schedule II, III and Xanax?

24 DR. WINCHESTER: Correct. Because that's
25 what the law says. Yeah.

1 CHAIRMAN BEARISON: So in essence then that
2 would allow for a long-acting, a short-acting
3 and a Xanax?

4 DR. TUCKER: Uh-huh.

5 DR. WINCHESTER: Right.

6 CHAIRMAN BEARISON: That's an average. In
7 as I think we heard before, some patients may
8 get one prescription and some patients may get
9 four.

10 DR. ROSENBERG: But that doesn't include
11 the language that Donna just suggested.

12 CHAIRMAN BEARISON: I thought it did.

13 DR. TUCKER: I thought it did.

14 VICE-CHAIR BURNS: Uh-huh, it did.

15 DR. ROSENBERG: Can you read it? Not to
16 exceed 150, but it didn't have the per patient,
17 per -- can you read -- can you read it back?

18 UNIDENTIFIED SPEAKER: Fifty patients per
19 day (not using microphone).

20 DR. TUCKER: Assuming 50.

21 DR. ROSENBERG: Okay.

22 CHAIRMAN BEARISON: Any other discussion on
23 that before we vote?

24 DR. ROSE: That's going to be based on per
25 physician at each facility?

1 DR. WINCHESTER: Correct. Per physician.

2 DR. ROSE: And that would encompass
3 anything that the PA or the ARP is doing as part
4 of the physician's work.

5 DR. WINCHESTER: Correct.

6 CHAIRMAN BEARISON: Is the prescription, I
7 guess, is the databank is going to get linked
8 back to that physician anyway because of an ARNP
9 or a PA can't write controlled substances.

10 DR. WINCHESTER: You know, part -- part of
11 the rationale for that is that, you know, that
12 would -- if you have a maximum of 50 patients,
13 and with the new requirements that are by
14 statute and rule on a patient, the doctor's
15 going to be pretty busy to see 50.

16 CHAIRMAN BEARISON: Okay. If no other
17 Committee member has a comment, then we'll just
18 go ahead and vote on that.

19 All in favor say, aye. (Committee members
20 responded.)

21 Opposed? (No response.)

22 Okay. Mr. Tellechea and staff, you have
23 your marching order regarding that.

24 MR. TELLECHEA: Okay.

25 CHAIRMAN BEARISON: Mr. McPherson?

1 MR. MCPHERSON: Thank you. Thank you,
2 members of the Committee.

3 Our next meeting is October 14 in Tampa,
4 Florida. And starting -- I think it starts at
5 8:00.

6 MS. SANFORD: Yes.

7 MR. MCPHERSON: Do we have a hotel yet?

8 CHAIRMAN BEARISON: Yeah, it's the airport.

9 MS. SANFORD: Airport Marriott.

10 MR. MCPHERSON: Airport Marriott.

11 CHAIRMAN BEARISON: And that's a Thursday,
12 I believe, correct? I don't know how we came up
13 with that.

14 DR. TUCKER: It's a Thursday?

15 CHAIRMAN BEARISON: Yeah.

16 MR. MCPHERSON: October 14 --

17 CHAIRMAN BEARISON: I'm almost positive.
18 Do you have a calendar?

19 MS. SANFORD: It is a Thursday.

20 DR. TUCKER: Yeah.

21 CHAIRMAN BEARISON: Yeah, I think it's a
22 Thursday.

23 VICE-CHAIR BURNS: It's a Thursday.

24 MR. MCPHERSON: Okay. All right. Thank
25 you very much members, Mr. Chair.

1 Thanks, of course, to all the staff that
2 put all this together.

3 CHAIRMAN BEARISON: Absolutely. You've all
4 done a perfect, wonderful job.

5 MR. MCPHERSON: Also thanks for all the
6 people out in the audience who --

7 CHAIRMAN BEARISON: We greatly appreciate
8 your input, and your code of conduct has been
9 exemplary, and I appreciate it very much.

10 DR. ROSENBERG: By the way, the star fruit
11 is for the audience as well, please.

12 CHAIRMAN BEARISON: Do any other Committee
13 members have anything else? (No response.)

14 Very good.

15 DR. ROSE: There's just a news thing I read
16 that there's a bid dispute on the prescription
17 drug monitoring database and the Department and
18 it may not be implemented in time.

19 This was in the Tampa Tribune. It's going
20 before an administrative law judge next month.
21 Just an FYI.

22 CHAIRMAN BEARISON: Very well. Thank you
23 very much, and I guess we're adjourned.

24 (The September 2010 Board of Medicine/
25 Osteopathic Medicine Pain Clinic Registration

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and Inspection Joint Committee Meeting concluded
at 1:22 p.m.)

CERTIFICATE OF REPORTER

STATE OF FLORIDA

ss:

COUNTY OF SEMINOLE

I, HEATHER K. HOWARD, Court Reporter,
hereby certify that I was authorized to and did
report the September 2010 Boards of Medicine and
Osteopathic Medicine Pain Management Clinic
Standards of Practice Joint Committee Meeting, and
that the transcript is a true and accurate
transcription of my notes and recordings.

I further certify that I am not a relative,
employee, attorney or counsel of any of the parties,
nor am I a relative or employee of any of the
parties' attorneys or counsel, nor am I financially
interested in the outcome of the foregoing action.

DATED this 16th day of September, 2010.

HEATHER K. HOWARD, Court Reporter
Notary Public-State of Florida

Notary Commission #DD 996777
Commission Expires: 06/07/14